Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 12, 2019	2019_768693_0002	008349-18, 021261-18, 023196-18, 024554-18, 025915-18, 026369-18, 027119-18, 027324-18, 027450-18, 027721-18, 027722-18, 027723-18, 027832-18, 028877-18, 029255-18, 030433-18, 031180-18, 031564-18, 032046-18, 032310-18, 033115-18, 001009-19, 001106-19	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street P.O. Box 3251 THUNDER BAY ON P7B 5G7

Long-Term Care Home/Foyer de soins de longue durée

Hogarth Riverview Manor
300 Lillie Street THUNDER BAY ON P7C 4Y7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MELISSA HAMILTON (693), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621), LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 21 to 25, 2019 and January 28 to February 1, 2019.

The following intakes were inspected upon during this Critical Incident System inspection:
- Two logs regarding infection prevention and control;
- nine logs regarding resident falls;
- one log regarding to an anonymous complaint;
- six logs regarding alleged resident to resident abuse;
- three logs regarding alleged staff to resident abuse/neglect;
- two logs regarding resident elopement; and
- one log regarding improper care of a resident.

Follow Up inspection #2019_768693_0003 and Complaint inspection #2019_768693_0004 were conducted concurrently with this Critical Incident System (CIS) inspection.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (ADOC), Regional Director Extendicare Assist, Clinical Managers (CMs), Infection Prevention and Control (IPAC) Facilitator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Assessment Instrument (RAI) Coordinators, Resident Home Workers (RHW), Therapeutic Recreationists, Staff Educator, Staffing Coordinator, complainants, Substitute Decision Makers (SDMs), residents and their family members.

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, home's internal investigation notes and complaints, staff education records, as well as reviewed numerous licensee policies, procedure and programs.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **6 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to minimize the restraining of residents was complied with.

The home submitted a Critical Incident System (CIS) report to the Director on a specified date, which identified an incident of improper/incompetent treatment that resulted in harm or risk to resident #006. The report outlined the use of a specific restraint of which there was no order for use, and no consent from the SDM.

Inspector #196 reviewed the home's policy "Least Restraints - Extendicare RC-22-01-01", last updated February 2017, which identified that the following was required when using a restraint device:
-"Obtain a Physicians Order for the restraint or where applicable (MB), a Nursing Order; and
-"Obtain consent a/ Consent is required from the resident, where possible, or the POA/SDM."

Inspector #196 reviewed resident #006's health care record and was not able to locate a Physicians order or a consent from the SDM for the use of a restraint device that was current at the time of the incident.

During an interview with RPN #102, they reported that on the shift of the incident, the PSWs were trying to do their work and couldn't because resident #006 was wandering and was about to fall over, and the resident had experienced a recent fall. The RPN directed the PSWs to restrain a resident in a specific mobility aid.

During an interview with the ADOC, they reported to Inspector #196 that RPN #102 did not follow or comply with the home's policy on least restraints, specifically, that a Physician's order and consent from the SDM had not been obtained prior to the use of the restraint. [s. 29. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy to minimize restraints is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and

v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): 5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

A CIS report was submitted to the Director related to an outbreak in the home. The CIS report indicated the outbreak was declared by public health on a specified date, and it was first reported to the Director on a later date.

The Inspector reviewed "Mandatory and Critical Incident Reporting (ON)" RC-09-01-06, last updated April 2017, which indicated, "The home will report and submit all Mandatory and Critical Incidents to the Ministry of Health and Long Term Care, within the required time frames, in accordance to the Ontario Long Term Care Homes Act, 2007", and under procedures it read, "Inform the MOH Director immediately, in as much detail as is possible in the circumstances, of each of the following incidents in the home: j. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act", and, "Make a report immediately following an incident, and if it is after normal business hours, report using the Ministry's method for after-hours emergency contact...".

During an interview with IPAC Facilitator #107, they reported that there was a delay in

reporting to the MOHLTC, for an unknown reason, and stated "human error" on their part. They further added they were aware that an outbreak was to be reported immediately, and the CIS regarding the outbreak should have been submitted immediately. [s. 107. (1) 5.]

2. The licensee has failed to ensure that the Director was informed, no later than one business day after the occurrence of the incident, followed by a report required under subsection (4): 4. Subject to subjection (3.1), an incident that caused injury to a resident, for which the resident was taken to hospital, and that resulted in a significant change in the resident's health condition.

A complaint was received by the Director on a specified date, which identified that resident #028 had sustained an incident with injury, and that a critical incident report was not submitted to the Director, as required.

During a review of resident #028's healthcare records, including progress notes from a specified date, RPN #111 documented that at an identified time, they heard the resident sustain an incident, and then found the resident in extreme pain with an area of their body very swollen and deformed. RN #112 reported at a later identified time that the resident had increased pain, and a specific area of their body appeared to be injured. At a later time, RN #112 contacted leadership, and indicated that the incident was not reported as critical until confirmation was received of the specific injury. RN #112 further reported that at an identified time the resident was transferred to hospital via ambulance. Lastly, RPN #113 documented, at at an identified time on a specific date, that the resident arrived back to the home from hospital at an identified time, with a confirmed specific injury to an identified area of their body.

During an interview with RN #114, they confirmed that on a specified date, resident #028 sustained an incident with injury. RN #114 reported that this kind of injury was considered a significant change in status, as the resident was sent to hospital as a result of the injury; had significant pain as a result of the fracture, required pain assessments and changes in medication management, and it affected a resident's Activities of Daily Living (ADL's), including such activities as bathing. RN #114 identified that any significant change in status was to be reported as a critical incident (CI), and reported to the unit manager, or if after hours, to the Manager On-Call. RN #114 also indicated, as part of the mandatory reporting process for critical incidents, that an internal "Critical Incident & Mandatory Reporting" form was to be completed by registered staff and provided to the unit manager; and that management would notify the Ministry of Health and Long-Term

Care (MOHLTC) of the incident and complete a respective CI report to the Director.

Inspector #621 reviewed a copy of the home's policy titled "Mandatory and Critical Incident Reporting (ON) – RC-09-01-06", last updated April 2017, which identified that the home would report and submit all Mandatory and Critical Incidents to the Ministry of Health and Long-Term Care Director no later than one business day after the occurrence of the incident that caused an injury to the resident that resulted in a significant change in the resident's health condition, and for which the resident was taken to hospital. Further, the policy identified that a "Significant change" means a major change in the resident's health condition that will not resolve itself without further intervention, impacts on more than one aspect of the resident's health condition, and requires an assessment by the interdisciplinary team or a revision to the resident's plan of care.

Inspector #621 reviewed a copy of the home's On-Call Schedule for a specific month which identified that CM #101 had been the manager on-call on an identified date.

During an interview with CM #101, they confirmed to Inspector #621 their role as manager on-call for the home on an identified date. They reported to the Inspector that they had received a call from the RN on duty that morning, which identified resident #028 had sustained an incident with suspected injury. CM #101 identified that they directed the RN at that time to complete a safety report, but not report it as a critical incident until the suspected injury was confirmed. On review of a copy of the On-Call Log for a specified date, CM #101 further reported to the Inspector that later in the day on the specified date, they received confirmation that the resident had sustained the specific injury,but needed confirmation on whether the injury affected the resident's ability to preform ADLs with alteration. CM #101 indicated that this identified injury was not always a significant change in status, as the resident could still perform specific ADLs.

Together with the Inspector, CM #101 reviewed the home's policy titled "Mandatory and Critical Incident Reporting (ON) – RC-09-01-06", last updated April 2017, and confirmed with the Inspector that based on the information outlined in the home's policy, that the injury of resident #028's specific area of their body would be considered a significant change in status, and that a CI report to the MOHLTC would have been required.

On review of the Long Term Care (LTC) Homes.net website, from the date of incident, until the time of inspection, CM #101 was unable to locate the submission of a mandatory critical incident report to the Director for this incident involving resident #028. Additionally, CM #101 reported that they and the ADOC reviewed documentation kept on file in CM

#115's office and were unable to find records to confirm that a CI and respective investigation of the incident had been completed on December 2, 2018, or any time thereafter. [s. 107. (3) 4.]

3. The licensee failed to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: Actions taken in response to the incident, including, the outcome or current status of the individual or individuals who were involved in the incident.

A CIS report was received by the Director on a specified date, concerning alleged neglect of resident #009. The report indicated that the resident had an irregularity to an identified area of their body and there had been concern regarding if resident #009 had been receiving consistent care to this area.

During a review of the home's CIS report, Inspector #577 found that CM #116 reviewed video tapes and had confirmed that resident #009 had received care by staff on the dates that were not documented in point of care. Additionally, they had a follow up with the staff who did not document care that was provided and a letter of coaching had been provided to staff.

During an interview with the ADOC, they could not provide any investigation notes which would have contained staff names, or any documentation from Human Resources. The ADOC confirmed that the CIS report had not been amended to include the required information. [s. 107. (4) 3. v.]

4. The licensee failed to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: Actions taken in response to the incident, including, the outcome or current status of the individual or individuals who were involved in the incident.

A CIS report was received by the Director on a specified date, concerning alleged neglect of resident #008. The report indicated that resident #008 had requested assistance with their continence and had not been provided assistance on an identified number of occasions throughout the shift.

Inspector #577 reviewed the CIS report and found that the report indicated that two staff

members were placed on a leave pending the investigation and that there were no lasting ill effects reported by the resident. The report did not indicate any amendments made or whether the allegation was founded or unfounded.

A review of the home's policy, "Mandatory and Critical Incident Reporting - RC-09-01-06", last revised April 2017, indicated that the documentation required in the critical incident report would include the outcome, the immediate actions that had been taken to prevent recurrence and the long-term actions planned to correct the situation and prevent recurrence.

During an interview with the ADOC, they confirmed to Inspector #577 that the allegation of neglect was unfounded and they had not amended the CIS report to include the actions taken, or the the outcome. [s. 107. (4) 3. v.]

5. A CIS report was received by the Director on a specified date, regarding an alleged incident of resident to resident abuse in which, resident #017 pushed resident #018 to the floor. The report indicated that resident #018 had pain to an identified area of their body, and the physician ordered a specific assessment to be completed. The report indicated that resident #018 had the assessment completed on an identified date.

Inspector #693 reviewed the home's submitted and amended CIS reports and identified that the outcome of the assessment and if any injuries were sustained was not documented in the CIS report amendments for resident #018.

Inspector #693 inquired to the Regional Director Extendicare Assist about this CIS report, and asked if it had been amended to include the results of the assessment and the outcome from this incident for resident #018. The Regional Director Extendicare Assist provided the inspector with an assessment report for resident #018 which indicated that an assessment was completed and no significant abnormalities were identified.

Inspector #693 obtained a copy of the home's policy titled," Extendicare: Mandatory and Critical Incident Reporting: RC-09-01-06", last updated April 2017. The policy indicated under the procedures for the Director of Care or Designate, that they were to include in the written report the actions taken in response to the incident including: the outcome or current status of the individual or individuals who were involved in the incident.

During an interview with the ADOC, they stated that to their knowledge, there were no further amendments completed for this CIS report as the home did not have record of

this. They stated that the CIS report was not amended to include the outcome; results of the assessment for resident #018. [s. 107. (4) 3. v.]

6. The licensee failed to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: Analysis and follow-up action, including, the long-term actions planned to correct the situation and prevent recurrence.

A CIS report was received by the Director on a specified date, concerning alleged neglect of resident #008. The report indicated that resident #008 had requested assistance with their continence and had not been provided assistance on an identified number of occasions throughout the shift.

Inspector #577 reviewed the CIS report and found that the report indicated that two staff members were placed on a leave pending the investigation. The report did not indicate any amendments made to have included follow-up action, including the long-term actions to correct and prevent recurrence.

A review of the home's policy, titled, "Mandatory and Critical Incident Reporting - RC-09-01-06", last revised April 2017, indicated that the documentation required in the critical incident report would include the outcome, the immediate actions that had been taken to prevent recurrence and the long-term actions planned to correct the situation and prevent recurrence.

During an interview with the ADOC, they confirmed to Inspector #577 that the allegation of neglect was unfounded; and they had not amended the CIS report to include the follow-up action, which should have included, the long-term actions planned to correct the situation and prevent recurrence. [s. 107. (4) 4. ii.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): 5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1), the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 3. Actions taken in response to the incident, including, i. what care was given or action taken as a result of the incident, and by whom, ii. whether a physician or registered nurse in the extended class was contacted, iii. what other authorities were contacted about the incident, if any, iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 107 (4), within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 4. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 107 (4), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A CIS report was received by the Director on a specified date, concerning alleged neglect of resident #009. The report indicated that the resident had an irregularity to an identified area of their body and there had been concern regarding if resident #009 had been receiving consistent care to this area.

Inspector #577 reviewed the Point of Care (POC) flowsheet documentation for resident #009 for a specified period of time, and found that on 40 per cent of these day shifts care was not documented. Additionally, for another specified period of time, on 39 per cent of evening shifts care was not documented. For another identified period of time, there was no consecutive documentation on the day shifts and; for another identified period of time there was no consecutive documentation on the evening shifts.

Inspector #577 reviewed the POC dietary report from a specified period of time, and found that 35 per cent of meals during this time period were not documented. Specifically, for an identified period of time, there was no consecutive documentation for two meals; and for another specified period of time, there was no consecutive documentation for another meal and snack.

A review of the home's policy titled, "Daily Personal Care and Grooming", last updated April 2017, indicated that care staff were directed to document the care provided on the Daily Care Record or electronic equivalent to indicate care given or refused.

During an interview with PSW #117, they reported that PSWs were required to document the care provided and dietary intakes for residents, for their shift on POC.

During an interview with PSW #109 and PSW #118, they reported that once per shift,

they documented the care they provided to residents on POC, which included activities of daily living, bathing, transferring, toileting, dressing, etc; furthermore, they were required to document intake of meals and nourishment on the POC dietary flowsheet. They further reported that they were required to document "activity did not occur" if the specific care was not provided.

During an interview with RAI Coordinator #119, they confirmed that the POC documentation was inconsistent and staff should have been documenting even if the activity did not occur.

During an interview with the ADOC, together with Inspector #577, they reviewed the incomplete documentation of POC dietary flowsheets and care flowsheets for resident #009. The ADOC confirmed that the POC documentation was inconsistent and staff were required to document the care they had provided.

CO #003 was issued during inspection #2018_624196_0024 pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 6. (9) with a compliance due date of December 19, 2018. As the compliance date was not yet due at the time of this CIS. This finding will be issued as a WN to further support the order. [s. 6. (9) 1.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A CIS report was received by the Director on a specified date, concerning alleged staff to resident abuse. The report indicated that RPN #100 had chastised resident #008 for

ringing their call bell, and left the resident's room without determining the care that resident #008 had needed.

O. Reg. 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that were performed by anyone other than a resident.

O. Reg. 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

Inspector #577 reviewed the home's policy titled,"Extendicare-Zero Tolerance of Resident Abuse and Neglect Program - RC-02-01-01", last revised April 2017, which indicated that there was zero tolerance for abuse and neglect and any form of abuse or neglect by any person, whether through deliberate acts or negligence, would not be tolerated.

A review of the home's internal investigation notes by Inspector #577, identified that RPN #100 received disciplinary action for neglect and emotional abuse, in accordance with the MOHLTC Resident Bill of Rights, due to failure to provide compassionate and respectful care towards resident #008.

During an interview with the ADOC they confirmed that based on the home's investigation, RPN #100 had been disciplined as they were found to be neglectful for not providing care to resident #008 and of emotional abuse, for having chastised the resident for using their call bell.

CO #001, and DR, was issued during inspection #2018_624196_0024 pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) with a compliance due date of December 19, 2018. As the compliance date was not yet due at the time of this CIS. This finding will be issued as a WN to further support the order and DR. [s. 20. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident who demonstrated responsive behaviours, strategies were developed and implemented to respond to those behaviours, where possible.

A CIS report was received by the Director on a specified date, concerning resident to resident abuse. The report indicated that resident #012 was found to have areas of altered skin integrity on an identified number of areas of their body, and had reported to staff that resident #011 kicked and hit them when they wouldn't give them a specific object.

Inspector #577 reviewed the physician's orders from an identified date, which, instructed nursing staff to document a Dementia Observation System (DOS) for two weeks, as the resident had increased agitation at a specified time of day.

A review of the resident's current care plan and kardex indicated the intervention to complete the DOS each shift for behaviours and medication refusal or acceptance.

Inspector #577 reviewed the DOS initiated on a specified date, and found inconsistencies in the documentation for an identified number of days and times. Additionally, on a specified date, the Inspector found that documentation was completed ahead of time for times that had not yet occurred.

During an interview with PSW #120, they reported that they were assigned to the care of resident #011, and together with the Inspector, reviewed the inconsistent documentation

on the DOS. They reported that they were too busy to document, but confirmed it was supposed to be documented every 30 minutes.

During an interview with PSW # 117, they reported that they were assigned to the care of resident #011. They further reported that they were not aware that resident #011 was on a DOS.

In an interview with RN #121, they reported that DOS documentation was not completed because the DOS form was on the incorrect PSW clip board, and probably had not been communicated between staff.

During an interview with the ADOC, together with the Inspector they reviewed the inconsistent documentation on the DOS. The ADOC reported that staff were required to have documented on the DOS every 30 minutes. [s. 53. (4) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's written record was kept up to date at all times.

Inspector #577 reviewed the DOS initiated on a specified date, and found inconsistencies in the documentation for an identified number of days and times. Additionally, on a specified date, the Inspector found that documentation was completed ahead of time for times that had not yet occurred.

During an interview with PSW #120, together with the Inspector, they reviewed DOS documentation for a specified period of time. The PSW reported that the DOS documentation was inconsistent, and was supposed to be documented every 30 minutes. The PSW confirmed that staff had completed the documentation for a specific time frame on an identified day; which included documentation for times that had not yet occurred and would have occurred on the next night shift.

During an interview with the ADOC, they reviewed the DOS documentation for resident #011 and stated that staff were required to document every 30 minutes on the DOS documentation. The ADOC confirmed with Inspector #577 the inconsistencies in the documentation from a specified period of time, as well that the staff had documented on an identified day, for a specific time frame, and that this was incorrect as these times had not yet occurred. The ADOC stated that they assumed that the staff from the night before must have documented on the incorrect day. [s. 231. (b)]

Issued on this 20th day of February, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.