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
Nov 14, 2018	2018_591623_0010	009732-18	Resident Quality Inspection

Licensee/Titulaire de permis

Haliburton Highlands Health Services Corporation
7199 Gelert Road Box 115 HALIBURTON ON K0M 1S0

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

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

SARAH GILLIS (623), KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): June 11, 12, 13, 14, 15, 18, 19, 20, 21, 22 and 25, 2018

The following intakes were inspected concurrently during this RQI inspection:
Log #007972-18 - Complaint related to alleged improper care and abuse of residents.
Log #020052-17 - Critical Incident Report - Related to an alleged resident to resident abuse
Log #003462-18 - Critical Incident Report - Related to an unexpected death of a

resident
Log #007469-18 - Critical Incident Report - Related to an alleged staff to resident abuse
Log #003632-18 - Critical Incident Report - Related to an alleged staff to resident abuse
Log #015258-18 - Critical Incident Report - Related to an alleged staff to resident abuse
Log #007017-18 - Critical Incident Report - Related to an unplanned evacuation of the building (partial)
Log #013696-18 - Critical Incident Report - Related to an alleged staff to resident abuse

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (ADM/DOC), Dietary Manager, Cook, Dietary Aide, RAI Coordinator, Registered Nurses (RN), IPAC/Occupational Health Nurse, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Life Enrichment Manager, Activity Aide, Housekeeping Aide, Director of Maintenance, Director of Facility Projects, Maintenance Worker, Physiotherapist Assistant (PTA), Physiotherapist (PT), Family Council Co-Chair, Resident Council President, residents and families.

Also during the course of this inspection, the inspectors toured the home, observed medication administration, infection control practices, staff to resident interactions, and resident to resident interactions, reviewed resident clinical health records, Pharmacy and Therapeutic meeting minutes, Resident Safety Committee meeting minutes, the Family and Resident Councils meetings minutes, the maintenance binder (for identified dates), the licensees investigation documentation, staff Education – specific to Zero Tolerance of Abuse, Residents Bill of Rights, Mandatory Reporting.

The following policies were also reviewed: Zero Tolerance of Abuse and Neglect, Responsive Behaviours, Housekeeping Department Routines, Spot Cleaning – Carpets, Carpet Cleaning, Cleaning and Disinfection of Non-Critical Medical Equipment and Devices, After Use of Nail Clippers and Other Personal Equipment, Identification of Residents and their Belongings, Hand Hygiene, Precautions and Isolation, Blood Glucose Monitoring, Insulin, Subcutaneous Injections, Insulin Injection Site Selection and Rotation, Medication Security and Accountability, Medication Incident/Near Incident Program, Skin and Wound Care Program, Falls

Prevention Program, Restraint Implementation Protocols, and Personal Assistance Service Device (PASD) policy.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **25 WN(s)**
- **17 VPC(s)**
- **4 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

During the initial tour of the long-term care home, the carpeting in the home was observed, by Inspector #554, to be stained. The stained carpeting was located throughout the resident home areas, specifically in residential hallways, and in the resident communal areas, adjacent to an identified area. The staining on the carpets was more extensive on a specific resident home area. A noticeable odour was also present as Inspector #554 entered the identified resident home areas.

While touring the long-term care home, stained carpeting was also observed, from the hallway, in specific identified resident rooms, both located on the same specific identified area of the home.

Stained carpeting in residential hallways, resident communal areas, and in specific identified resident rooms, was observed to be stained on a number of specified dates. Stained carpeting was also observed, by Inspector #554, in another specific identified resident room on a number of identified dates.

Resident #021, indicated to Inspector #554 on a specific date, that the carpets in the home are of concern, and need professional cleaning or replacement.

Substitute Decision Maker (SDM) #036 and SDM #033 indicated to Inspector #554 on different identified dates, that they have concerns with the cleanliness of the carpets in the long-term care home.

Housekeeping Aide (HSK) #111 indicated, to Inspector #554 on a specific date, that the carpeting in the long-term care was approximately eighteen years old. HSK #111indicated that the stained carpeting has been an area of concern for some time, and has been brought up at Environmental Staff Meetings by staff to managers, specifically departmental manager and to the Administrator, on more than one occasion. HSK #111 indicated that the 'extractor' used for carpet cleaning is constantly breaking down, and indicated that 'staff are told by management that there is no money to replace the extractor'. HSK #111 indicated that the carpeting in residential hallways, common areas (e.g. lounges) and in resident rooms is 'not consistently cleaned as housekeeping staff lack the time, and the equipment'. HSK #111 indicated that the 'staining on the carpet is from every day wear and tear, food and beverages being spilled on the carpets and from residents at times urinating on the carpets'. HSK #111 indicated it is their belief that the carpeting in the home is a contributing factor to the odour in the long-term care home.

Director of Environmental Services and Plant Operations (DESPO) indicated, to Inspector #554 on a specific date, that they have been in the role for a specific period of time, and has identified that carpeting in the long-term care home are 'extensively stained, and in need of cleaning'. DESPO indicated that housekeeping staff do 'spot clean' carpets as needed. DESPO indicated that they believe the carpets in the long-term care home are to be cleaned yearly, but indicated they do not know that last time carpeting in the home had been cleaned. DESPO indicated that a quote has been requested by an external service provider, but indicated that they were unsure of the status of the quote at this time, and indicated that the approval for such costs would come from the Director of Facility and Projects (DESPO's manager) and the Chief Financial Officer. DESPO indicated that it is their belief that the carpets in the long-term care home contributes to the odour in both resident home areas.

The Director of Facility and Projects indicated, to Inspector #554 on a specific date, that at this time no quotes and/or approval had been received for the carpets in the long-term care home to be cleaned.

The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary, specifically the carpeting in the long-term care home.

2. The licensee has failed to ensure that the home, furnishings, and equipment are maintained in a safe condition and in a good state of repair.

Related to Intake Log #007017-18

During the initial tour of the long-term care home (LTCH), the following was observed by Inspector #554:

In a specified Resident Home Area (RHA)
- Ceiling tiles: observed to have brownish staining on two ceiling tiles in the hallway outside of specific identified resident rooms; one ceiling tile was observed stained outside of another specific identified resident room.

- Balcony Patio Area #1: wooden floor boards, on the balcony-sitting area, were observed to be uneven and lifting in areas, screws on the floor boards were observed absent in areas. One resident was observed sitting outdoors on the balcony-sitting area.

- Balcony Patio Area #2: wooden floor boards were observed uneven and lifting in areas; the paint on the floor boards was observed chipped, there was weeds and grass extending from the hillside onto the decking. A sign on the door to the balcony area indicated 'balcony temporarily closed'. The door to the balcony was locked.
- Specific identified Resident Room: ceiling tiles observed stained, four ceiling tiles were observed off, exposing pipes and wiring in the ceiling, and the carpet was observed stained. The resident room was not in use. The resident who had been residing in the identified room had been relocated temporarily to another location within the LTCH due to the roof leaking into their room.
- Resident Staff Communication and Response System (main box): observed to have duct tape across the system, and a plastic cup taped to the volume control.

Specific identified RHA
- Carpeting: heavily stained carpets were observed in the main common area, adjacent to nursing station and dining room. This was observed on both RHA's. Carpeting was also observed stained in a specific identified resident.
- Walls: observed to have dry wall putty visible on walls throughout the hallways, to the right as you enter the identified RHA.
- Commode: observed to have one side arm missing (left side). The commode was observed in the tub-shower room, in a specific identified RHA.
- Door Bells: observed to be non-functioning on both of the exit/entry doors of the secured courtyard. This is a resident accessible area. Residents were observed using the courtyard at the time of this observation.
- Ceiling Lights: observed non-functioning in the hallway, outside of two specific identified resident room. Ceiling lights remained non-functioning on a number of specified

dates during the inspection.
- Outdoor Patio Area: weeds and grass was observed extending into the outdoor patio area from the hillside. Overgrown weeds and grass were observed growing between the patio stones. This patio was accessible to residents.

The maintenance binder was reviewed by Inspector #554 covering the period of four months, there is no mention in the maintenance binder of the above identified areas needing repair and or replacement.

Two Substitute Decision Makers, for specific identified residents residing in the LTCH, indicated, to Inspector #554 on two separate identified dates, that it is their belief the home is not being maintained, and is in need of repair.

Housekeeping Staff (HSK) #111 indicated, to Inspector #554 on a specific date, that carpeting in the LTCH was heavily stained as they, the housekeeping staff, did not have the equipment, specifically a carpet extractor, to maintain the carpets. HSK #111 indicated that the carpet extractor is frequently broken and that housekeeping staff were told in a staff meeting that there was 'no money to fix the extractor'. HSK #111 indicated that there is one carpet extractor in the LTCH, but such is not adequate to keep up with the work required within the LTCH.

Maintenance Staff #122 indicated, to Inspector #554 on a specific date, that the ceiling tiles in the LTCH are stained due to the roof leaking. Maintenance Staff #122 indicated that the roof of the LTCH has been leaking for some time, and indicated that the roof had been leaking prior to the current DESPO's arrival seven months ago, and indicated that on a specified date two residents had to be relocated due to the water from the roof leaking into their rooms. Maintenance Staff indicated that the maintenance workers have been told to patch the roof but indicated that such repairs are 'bandage solutions' and indicated they, the maintenance staff have no roofing experience. Maintenance Staff #122 indicated that the balconies in the LTCH have been in need of repair for years. Maintenance Staff #122 indicated that the main box for the resident-staff communication and response system had been broken since an identified date, indicating at times the volume is so low staff can't hear resident's ringing for assistance. They indicated that external contractors had been in to look at the system and had indicated that the system is obsolete and there are no parts available to repair it. Maintenance Staff #122 indicated they had been told 'there is no money available for repair or replacement' of the balconies and or the resident-staff communication and response system. Maintenance #122 indicated being unaware that the door bells in the courtyard were non-functioning.

Maintenance Staff #122 indicated we try to keep up to what needs repairing but at times difficult as they cover maintenance on the hospital side too.

The Director of Environmental Services and Plant Operations (DESPO) indicated, to Inspector #554 on a specific date, the following:
- that they were aware the carpets in the LTCH are heavily stained, and indicated that such maybe contributing to the odours in the home. DESPO indicated that they are aware that one of the carpet extractors is broken. DESPO indicated that there is no plan in place to repair and or replace the carpet extractor as of this time. DESPO indicated they have been told by their supervisor, the Director of Facility and Projects and/or the Director of Finance that there no funds to repair and or replace the carpet extractor.
- that the ceiling tiles in the home are stained due to the roof leaking. DESPO indicated that the roof of the LTCH has been leaking since the 'first thaw' in January 2018. DESPO indicated that there has been external service providers in to look at the roof but as of this time, that they have not received quotes and or approval for repairs of the roof. DESPO indicated being aware that two residents had been relocated due to the roof leaking into their rooms. In a second interview DESPO indicated they had been told that the roof had been leaking prior to a specified date, but they were not entirely sure as they had just begun the role of DESPO seven months ago.
- being aware that the identified balcony area, is in need of repair. DESPO indicated not being aware that the balcony had been closed. DESPO again indicated being told that there was no funds to repair the balcony as of this time. DESPO indicated being unaware of uneven or lifting boards on the other identified balcony facing. DESPO indicated that the upkeep of the balconies and or outdoor sitting areas should be maintained, but indicated being unsure whose responsibility it was to remove overgrown weeds and/or grass from such areas.
- being unaware that door bells in an identified area were non-functioning. DESPO indicated being unaware that the courtyard and or balcony had door bells.

On a specified date, three more ceiling tiles were observed to be stained, and appeared 'wet' outside of two specific identified resident rooms; two ceiling tiles observed stained outside of a third identified resident room; four ceiling tiles stained outside of a specific identified resident communal area; and two ceiling tiles were observed stained outside of the specified RHA lounge, adjacent to the balcony. These eleven ceiling tiles were not observed to be stained during the initial tour seven days prior.

The Director of Facility and Projects indicated, to Inspector #554 on a specified date, being aware that the roof in the LTCH needed repair or replacement, and also indicated

being unsure how long the leaking roof had been an issue. The Director of Facility and Projects indicated being aware that resident's residing in the home had been relocated due to the roof leaking, but indicated being unsure if residents remain dislocated. The Director of Facility and Projects indicated that request for contract had been recently placed in the paper, but contractors had until a specified date to visit the site and bid on the contract. The Director of Facility and Projects indicated further that the hope was to have the roof repaired by end of a specified date, but indicated that such approvals are beyond their scope.

The Administrator indicated, to Inspector #554 on a specified date, being aware that the roof of the LTCH was in need of repair, and indicated that two resident's had been relocated, within the LTCH, due to water leaking into their rooms. Administrator indicated that as of this time, a third resident has had to be relocated within the home due to the roofing issues. The Administrator indicated having not heard of when the roof will be repaired, and or when the three identified residents can return to their assigned rooms. The Administrator indicated that the roof in the LTCH had been leaking prior to a specified date, and prior to the current DESPO taking on their role.

The Administrator indicated being aware that the balconies/outdoor sitting areas RHA's needed repair. The Administrator indicated there is no plan in place to repair and or replace these areas as of this time. The Administrator indicated that they were not told that the specific identified balcony, had been closed. The Administrator indicated that the areas are for resident use, and indicated some resident's had voiced concern with not being able to use the one identified balcony. The Administrator indicated being unaware that the door bells on courtyard doors are non-functioning.

The Administrator, who is to oversee the operations of the LTCH, indicated not being kept abreast of needed repairs in the LTCH as the DESPO does not report directly to them, but reports to the Director of Facility and Projects, and that such communications is not shared.

The DESPO and the Administrator indicated that the LTCH is maintained in a safe condition and in a good state of repair, for the safety and well-being of the residents residing in the LTCH.

On the final day of this on-site inspection, residents assigned to specific identified resident rooms remained dislocated from their assigned rooms. The required repairs and/or replacement, identified by Inspector #554, on a specified date, remain a concern.

The licensee has failed to ensure that the home, furnishings, and equipment are maintained in a safe condition and in a good state of repair.

Additional Required Actions:

CO # - 001, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, is on at all times; allows calls to be cancelled only at the point of activation; is available in every area accessible by residents; that it clearly indicates when activated where the signal is coming from; and in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

During the initial tour of the long-term care home (LTCH), it was observed, by Inspector #554, that four specific separate identified home areas, did not have a resident-staff communication and response system available.

Personal Support Worker (PSW) #113, Registered Nurse (RN) #112, Maintenance Staff #122, and the Administrator-Director of Care (ADM-DOC) indicated to Inspector #554, that the specific identified areas are considered resident accessible areas.

RN #112, Maintenance Staff #122, and the ADM-DOC indicated that the door bells located in the specific identified home areas are not part of the resident - staff communication and response system.

Maintenance Staff #122 indicated that the audible sound of the door bells, to alert staff that residents or others need assistance, are not calibrated.

During interviews with RN #122, Maintenance Staff #122, and the ADM-DOC, as well as observations it was concluded that the door bells in use for specific identified resident home areas, do not comply with O. Reg. 79/10, s. 17 (1) (b) (c), (f) and (g).

The DESPO, and the ADM-DOC indicated that they were not aware that outside resident accessible areas were required to have resident-staff communication and response system available.

The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, is on at all times; allows calls to be cancelled only at the point of activation; is available in every area accessible by residents; that it clearly indicates when activated where the signal is coming from; and in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

During the initial tour of the long-term care home by Inspector #554, a lingering offensive odour was noticeable as you entered both the upper and lower resident home areas. The odour was worse on the lower level resident home area. The odour resembled urine.

Inspector #554, noted a similar odour in a residential hallway on a specified home area, the odour was increasingly offensive as the Inspector walked past and entered a specific identified room that is shared by two residents.

The lingering offensive odour was noted to be present over the course of the entire inspection, throughout all resident home areas, and as Inspector #554, walked by and/or entered a specific identified resident room.

On a specified date, two visitors were observed walking in a residential hallway in a specific identified resident home area (same hallway as the identified resident room), and were overheard by Inspector #554 to comment on the smell.

Personal Support Worker (PSW) #110 indicated, to Inspector #554 on a specified date, that both residents residing in the specific identified resident room require total care by staff, and were incontinent. PSW #110 indicated that the odour in the identified resident room is frequently present, and indicated that the odour has been worsening over time.

PSW #110 indicated that the odour 'smells like urine'. PSW #110 indicated that they assume that housekeeping staff and the Administrator are aware of the odour issue, as the odour is not a new issue in the home.

Housekeeping Aide (HSK) #111 indicated, to Inspector #554 on a specified date, that there has been an odour issue in the long-term care home for some time. HSK #111 indicated that some resident rooms, and common areas (e.g. lounges/sitting areas) 'smell like urine' as there are residents residing in the home who are known to 'urinate inappropriately in areas' within in the home. HSK #111 indicated that the specific identified resident room often smells of urine, as both residents are incontinent and exhibit responsive behaviours. HSK #111 indicated that other issues contributing to odours in the home are, that food and beverages are often spilled on the carpeting and that spills are not immediately cleaned up by staff. HSK #111 indicated it is their belief that the stained/soiled carpeting in the home is another contributing factor to the odour in the long-term care home.

HSK #111 indicated that other than daily cleaning, using a daily disinfectant, and an aerosol spray air freshener there is no other policy and or procedure for addressing lingering offensive odours in the long-term care home. HSK #111 indicated that odour concerns have been brought forth at Environmental Staff Meetings.

The Director of Environmental Services and Plant Operations (DESPO) indicated, to Inspector #554 on a specified date, that they were aware that the long-term care home has a lingering offensive odour, and indicated that the odour 'hits you as you enter specific identified areas' of the home. DESPO indicated that it is their belief that the carpets in the home are contributing to the odour.

DESPO indicated that they were uncertain if there was a policy or procedure in place for addressing lingering offensive odours, but indicated that they would check with the Administrator, covering the long-term care home on that specified date. DESPO indicated to Inspector #554 later that day, that the Administrator (covering the home) indicated that there is was no policy or procedure for addressing lingering offensive odours in the home.

The licensee has failed to ensure that procedures were developed and/or implemented for addressing incidents of lingering offensive odours in the long-term care home. [s. 87. (2) (d)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out, the planned care for the resident, related to nail care.

Related to Intake #007972-18:

Resident #023 has specific identified medical diagnosis which includes physical and cognitive limitations.

Personal Support Worker (PSW) #116 indicated, to Inspector #554, that they witnessed an alleged incident of staff to resident abuse, on a specified date, involving resident #023. PSW #116 indicated that they observed PSW #119 providing specific grooming to resident #023, at the nursing station; PSW #116 indicated that resident #023 was heard screaming and indicated that resident #023 told PSW #119 to stop more than once. PSW #116 indicated that PSW #119 continued to provide specific grooming to resident #023, and indicated that this interaction continued for approximately ten minutes or more. PSW #116 indicated that other residents and a visitor witnessed this alleged staff to resident abuse.

Substitute Decision Maker (SDM) #036, who is the SDM for another resident, indicated, to Inspector #554, that they witnessed the specified staff to resident incident. SDM #036 indicated that the incident was 'disturbing'. SDM #036 indicated 'there must be another way to provide specific grooming to a resident'.

The clinical health record, for resident #023, was reviewed for a specified period. The written plan of care reviewed fails to provide the planned care for specific grooming of resident #023.

PSW #119 indicated, to Inspector #554, that they are not aware of any specific planned care for the specific identified grooming of resident #023. PSW #119 indicated that the specified care for resident #023 'has to be done' and indicated that 'normally they are the only PSW that will do it'. PSW #119 indicated that resident #023 has a specific medical diagnosis, and that performing the specific identified grooming for this resident is difficult for one staff to do.

The licensee has failed to ensure that there was a written plan of care for resident #023 that sets out the planned care for the resident related to specific grooming. [s. 6. (1) (a)]

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 by ensuring that the written plan of care for each resident sets out the planned care for the resident, related to specific grooming, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with;

The licensee has failed to comply with the contracted pharmacy policy 3-028 – Specific medication – as part of the medication management program under O.Reg. 79/10, s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

Haliburton Highlands Health Services – Hylandcrest Long-term Care has National Pharmacy as their pharmacy service provider.

National Pharmacy - Specific Medication Policy #3-028

The specific identified medication must be safely administered in LTC facilities using either vials and syringes, with pens using refillable cartridges, or with pre-filled, disposable pens. Regardless of the method used that facility must ensure proper handling of the specific identified medication and device as well as proper technique for injection.

Before administering a specific medication by injection, the nurse must:

7. Prime needle by dialing 2 units of the specific medication and pressing the injection button to ensure the medication is in the needle thus avoiding injection of air which can inhibit absorption.

On a specific date and time, during an observation of the medication administration, RPN #104 prepared resident #028's specific medication for injection. The RPN did not prime the needle tip after placing it on the medication pen, the prescribed amount of medication was dialed up on the pen and administered as ordered to the resident. RPN #104 was then observed to prepare medications for resident #027, Inspector #623 observed the RPN place the needle tip on the pen, dial up the prescribed amount of medication, and administer it to resident #027 without priming the needle tip.

During an interview with Inspector #623 at the time of the medication observation, RPN #104 indicated that it was not necessary to prime the needle tip when using the medication pen.

On a specified date, during an interview with Inspector #623, RN #112 indicated that when administering specific medication using a pen, you are required to prime the needle prior to administration to ensure that the correct does of medication is administered.

On a specified date and time, During an interview the Admin/DOC for Highland Woods covering for the Hylandcrest Admin/DOC, indicated that they were not familiar with the policy for specific medication injection with a pen, or if the pen needle tips require to be primed.

The licensee failed to ensure that any plan, protocol, procedure, of system instituted or otherwise put in place is complied with related to the required medication management program, for the safe administration of medication. [s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place is complied with;

The licensee has failed to comply with Haliburton Highlands Health Services Policy #VI-G-30.10 (last reviewed February 2014) Specific identified testing – as part of the medication management program under O.Reg. 79/10, s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

Haliburton Highlands Health Services Policy #VI-G-30.10 (last reviewed February 2014) Specific identified testing

Policy:

Each resident requiring specific identified testing will have a physician order specifying the frequency of testing and will have their own assigned testing meter and device. Registered Staff will use the manufacturer's instructions to both calibrate the meter and conduct the testing on the resident.

On a specific date and time, during an observation of medication administration, RPN #104 was observed to use a specific testing meter to test resident #027. RPN #104 was then observed to use the same specific testing meter to test resident #028 without cleaning the meter in between residents.

On a specific date and time, during an interview with Inspector #623, RPN #104 indicated that each resident has a dedicated meter but resident #027's meter is "away being fixed", so staff use resident #028's meter for both resident's. RPN #104 indicated that the meter is not cleaned between residents.

On a specific date, during an interview RN #112 indicated that every resident who requires a specific test, has their own equipment, the equipment is not to be shared. RN #112 indicated that if the resident's dedicated equipment was broken, there are new meters available at all times.

On a specific date, during an interview with Inspector #623, the Admin/DOC indicated that every resident in the home who requires a specific test has their own equipment and the equipment is not to be shared. The Admin/DOC indicated that If a meter was broken, there are replacement meters available, the nurse would need to let the Admin/DOC

know. The Admin/DOC indicated that they were not aware of any resident that does not have their own meter.

The licensee failed to ensure that any plan, protocol, procedure, or system instituted or otherwise put in place is complied with related to the required medication management program, for the safe monitoring of specific identified levels. [s. 8. (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 by ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #6: 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 failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

The licensee's policy, 'Zero Tolerance of Abuse and Neglect', (#VII-G-10.00) (dated July 2016) indicates that Haliburton Highlands Health Services (HHHS) has a zero tolerance of abuse and neglect of residents. The Zero Tolerance of Abuse and Neglect policy directs that all staff members have an obligation to report any suspected or alleged abuse. The policy indicates that all staff are to immediately report the alleged, suspected or witnessed abuse immediately to the Charge Nurse.

Related to Intake #007972-18, and #015258-18:

Personal Support Worker (PSW) #116 indicated, to Inspector #554, that they witnessed an alleged incident of staff to resident abuse, on a specified date, involving resident #023. PSW #116 indicated that they observed PSW #119 grooming resident #023, at the nursing station; PSW #116 indicated that resident #023 was heard screaming and indicated that the resident told PSW #119 to stop more than once. PSW #116 indicated that PSW #119 continued to groom resident #023, and indicated that this interaction continued for ten minutes or more. PSW #116 indicated that other residents and a visitor witnessed this alleged staff to resident abuse.

PSW #116 indicated that alleged, suspected or witnessed abuse is to be immediately reported to the Charge Nurse. PSW #116 indicated they had reported what they witnessed, to Registered Practical Nurse (RPN) #133. PSW #116 indicated that they did not recall reporting the incident to the Charge Nurse. PSW #116 indicated that the Charge Nurse scheduled on that specific date, was Registered Nurse (RN) #112.

RPN #133 was not available to be interviewed during this inspection.

RN #112 indicated, to Inspector #554 during an interview, that they were the assigned Charge Nurse on the specific identified date. RN #112 indicated that staff are to immediately report allegations of abuse to the Charge Nurse. RN #112 indicated that they were not aware of any alleged, suspected or witnessed abuse on that specific date, involving PSW #119, and resident #023.

The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

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 by ensuring that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee failed to ensure that the temperature in the home is maintained at a minimum of 22 degrees Celsius.

Substitute Decision Maker (SDM) for resident #001 indicated, to Inspector #554 on a specific date, that the long-term care home, specifically an identified resident home area (RHA), is often cold. SDM indicated that resident #001 is often cold; SDM indicated they arrive to find resident #001 'shivering' while in their chair or while in the washroom. SDM further indicated that 'other residents' residing on the same RHA also complain of the RHA being cold.

On June 21, 2018, Inspector #554 observed the following temperatures:
- Hallway Temperatures - the thermostat, located on the wall for a specific RHA was observed registering an air temperature of 70 degrees Fahrenheit (F) (which is 21.1 degrees Celsius (C)).
- Dining Room – mercury thermometer, located on the wall in the dining room of the specified RHA was observed registering an air temperature of 70 F. The air conditioning (AC) unit in the dining room was turned on and set at 67 F (which is 19.4 C).

On a specific date, residents #010, and #038 were observed, by Inspector #554, sitting in a specific resident area, and both residents stated to staff that they were cold.

On a specific date, the thermostat, located on the wall for a specific RHA, was observed registering an air temperature of 70 F (21.1 C).

Maintenance Staff #121 indicated, to Inspector #554, that it was their belief that the air temperature according to the regulation should be 22 C. Maintenance Staff #121 indicated the heating, ventilation and air conditioning system (HVAC) consists of a Geo-Thermal and hot water boiler system. Maintenance Staff #121 indicated that the HVAC system is computerized, and is monitored by maintenance staff at minimum of daily.

The computerized HVAC system for the long-home care, was shown to Inspector #554 by Maintenance Staff #121. The computerized HVAC system was observed to have a 'set point' of 20.1 C.

Maintenance Staff #121 indicated that the 'set point' is set to 20.1 C, and indicated this allows the building not to get too hot, especially in the summer time. Maintenance Staff #121 indicated that the HVAC system is not adjusted by the maintenance staff, but controlled externally by Eco-Systems (a contracted service provider).

Maintenance Staff #121, and the Director of Maintenance Services indicated that they were aware that residents had voiced concerns regarding the specific RHA being cold at times. Both indicated that this is a problem with staff adjusting the AC unit in the specified area; Maintenance Staff #121 indicated that staff find it too hot, so they adjust the temperature on the AC to make it colder for them (the staff). Maintenance Staff #121 indicated that a lockable cover had in the past been placed over the thermostat in the dining room to prevent staff from adjusting the AC unit, but indicated that staff had used a knife to pry it open and have broken it.

The licensee has failed to ensure that the temperature in the home is maintained at a minimum of 22 degrees Celsius. [s. 21.]

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 by ensuring that the temperature in the home is maintained at a minimum of 22 degrees Celsius, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:
(i) Abuse of a resident by anyone
(ii) Neglect of a resident by the licensee or staff ,or
(iii) Anything else provided for in the regulations.

Related to Log #013696-19 for CIR

On a specific date, during stage 1 of the Resident Quality Inspection (RQI) when conducting a resident interview, resident #016 indicated that they were afraid of the way that PSW #105 spoke to resident #021. Resident #016 indicated that every time PSW #105 is working, they can be heard speaking to resident #021 in a rude and demeaning way, Resident #016 indicated that they have reported this to the charge RN as well as to the DOC on several occasions. Resident #016 indicated that this has been happening for some time.

On a specified date, Inspector #623 met with the Admin/DOC to report the allegation of abuse that was brought forwards by resident #016, related to resident #021. The Admin/DOC indicated that they were unaware of this allegation, but would conduct an internal investigation related to the reported concerns.

A Critical Incident Report (CIR) #M542-000013-18 was submitted to the Director on a specific date and time, for the allegation of abuse incident that was reported to the Admin/DOC two days earlier, by Inspector #623. The CIR identified the date of the incident as the date the CIR was submitted.

June 19, 2018, during an interview with Inspector #623, the Admin/DOC indicated that they did not investigate the allegation of verbal abuse immediately upon becoming aware on a specific date and time. The investigation was initiated two days later.

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse by anyone, that the licensee knows of, or that is reported is immediately investigated. [s. 23. (1) (a)]

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 by ensuring that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: abuse of a resident by anyone, neglect of a resident by the licensee or staff, or anything else provided for in the regulations, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the 24 hour admission care plan identified, at minimum, any risk a resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.

Related to Intake #020052-17

Resident #022 was admitted to the long-term care home (LTCH), as a short-term admission on a specified date.

An admission document indicated that resident #022 was known to exhibit specific identified responsive behaviours.

Registered Nurse (RN) #112 indicated, to Inspector #554 on a specified date, that when residents are admitted to the LTCH registered nursing staff review the admission documents and then they initiate a '24 Hour Care Plan' based on the document, and indicated that the plan is to include, the admitted resident's activity of daily living,

continence care needs and behavioural risk.

The clinical health record, for resident #022 was reviewed by Inspector #554.

The '24 Hour Care Plan' for resident #022, written by registered nursing staff on a specified date, identified that resident #022 exhibited specific identified responsive behavoiurs. The identified trigger, on this document was identified as 'inability to do things'. The 24 Hour Care Plan on admission, fails to identify safety measures in place to mitigate risk associated with the identified responsive behavoiurs.

Resident #022 was admitted for additional respite stays on seven other dates in the same year.

The 24 Hour Care Plan for admissions on three specific dates of respite stays, identifies that resident #022 exhibited three specific identified responsive behaviours. Identified the trigger to identified responsive behaviours as 'inability to do things'. The 24 Hour Care Plan for, the three specified dates of admission fails to identify safety measures in place to mitigate risk associated with three specific identified responsive behaviours.

A review of the clinical health record fails to provide documented support that a 24 hour admission care plan was implemented or completed, by registered nursing staff and or others, for admissions on four specified dates, specific to any risk resident #022 may pose to others, including any potential behavioural triggers, and safety measures to mitigate such risk.

Resident #022 was admitted as a permanent admission to the LTCH on a specified date, the 24 hour care plan identifies that resident #022 exhibits specific identified responsive behaviours, but fails to provide identified triggers and or associated interventions. Interventions were not identified in the care plan until 14 days later.

On a specific date, resident #010 was physically abused by resident #022, one day following the permanent admission of resident #022. The alleged physical abuse resulted in injury to resident #010. A Critical Incident Report was submitted to the Director.

RN #112, who was a Charge Nurse, indicated that it would be an expectation that a 24 hour care plan be implemented to identify the exhibited responsive behaviour, identified triggers and interventions in caring for resident #022, as well as the safety of others. RN indicated that there should have been a 24 hour care plan for each admission of resident

#022 in the specified year. RN #112 reviewed the clinical health record and was unable to locate a 24 hour care plan for resident #022 during four specific identified dates. RN #112 indicated that each admission, in the identified year, resident #022's exhibited responsive behaviours had worsened, and their behaviours placed others at risk of harm.

The Administrator-Director of Care indicated, to Inspector #554, that a 24 hour care plan should have been implemented for all dates when resident #022 was admitted to the LTCH for a respite stay in the identified year, and such documentation should have included exhibited responsive behaviour, identified triggers and interventions for the care of resident #022 and safety of others as needed. The Administrator-Director of Care indicated that a care plan should have been in place within 24 hours of the resident's admission to the LTCH. The Administrator-Director of Care indicated that they had also reviewed the health care record for resident #022 and was unable to locate an admission care plan for the four specific identified respite stay dates. Administrator-Director of Care further indicated that the 24 hour care plan for resident's admission on a specified date, which was a permanent admission, did not include interventions specific to the identified exhibited responsive behaviours. The Administrator-Director of Care indicated that the first interventions found in the written care plan were not implemented until 14 days following the permanent admission, according to the health record.

The licensee has failed to ensure that the 24 hour admission care plan identified, at minimum, any risk resident #022 may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. [s. 24. (2) 2.]

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 by ensuring that the 24 hour admission care plan identifies, at minimum, any risk a resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that, abuse of a resident by anyone, had or may occur, immediately report the suspicion and information upon which it was based to the Director.

Under LTCHA, 2007, s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act,

"emotional abuse" means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident;

"verbal abuse" means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Related to Intake #007469-18:

The Administrator-Director of Care (ADM-DOC) submitted a Critical Incident Report to the Director, on a specified date, specific to an alleged incident of staff to resident

verbal/emotional abuse. The CIR indicated that the alleged abuse which occurred five days prior, and involved resident #026.

The ADM-DOC indicated, to Inspector #554, that they had received a written communication (email) from Registered Nurse (RN) #129, on a specified date, regarding an allegation of staff to resident verbal abuse which occurred five days prior. ADM-DOC indicated that the written communication was dated three days after the incident occurred. ADM-DOC indicated that RN #129 was the Charge Nurse on the date the email was sent.

The written communication, documented by RN #129 on the specified date, was provided to Inspector #554 by the ADM-DOC. The written communication indicated, that on the identified date, PSW #108 had reported to RN #129, and RN #130, that an incident was witnessed where PSW #116 had been verbally abusive to resident #026. PSW #108 indicated that the alleged abuse incident occurred three days prior.

RN #129 and RN #130 were not available for an interview during this inspection.

ADM-DOC indicated that both RN #129 and RN #130 had been provided annual training specific to the licensee's zero tolerance of abuse policy, and both RN's are aware that abuse is to be immediately reported to the Director.

ADM-DOC indicated that the alleged staff to resident abuse was reported to the Director five days after the incident occurred.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that, abuse of a resident by anyone, had or may occur, immediately report the suspicion and information upon which it was based to the Director. [s. 24. (1)]

2. The licensee failed to ensure that a person who had reasonable grounds to suspect that, abuse of a resident by anyone, had or may occur, immediately report the suspicion and information upon which it was based to the Director.

Under LTCHA, 2007, s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act,

- "emotional abuse" means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning,

ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident;

- "verbal abuse" means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Related to Intake #003632-18:

The Administrator-Director of Care (ADM-DOC) submitted a Critical Incident Report to the Director, on a specified date, specific to an alleged incident of staff to resident verbal/emotional abuse. The CIR indicated that the alleged abuse which occurred four days prior, involved resident #030 and resident #037.

Substitute Decision Makers (SDM) #033 and #034, for both residents, indicated, to Inspector #554 during an interview, that the incident took place on the morning of a specified date, and was reported that same morning to the ADM-DOC. SDM #034 indicated that they had arrived to visit their 'loved ones' on the specified date, and found resident #030 in their room 'crying'. SDM #034 indicated resident #030 was 'distraught from an interaction with a personal support worker (PSW).

ADM-DOC indicated, to Inspector #554, that they were notified of the alleged abuse of resident #030 and resident #037 by PSW #128, on the date the alleged incident occurred. ADM-DOC indicated that that were aware of the reporting requirements under section 24 of the Act. ADM-DOC indicated that they 'must have gotten busy, and forgot to immediately report the incident' to the Director.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that, abuse of a resident by anyone, had or may occur, immediately report the suspicion and information upon which it was based to the Director. The ADM-DOC failed to report an allegation of staff to resident verbal/emotional abuse to the Director until four days following that incident. [s. 24. (1)]

3. The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse or a resident by anyone has occurred or may occur, immediately report the suspicion and information upon which it was based to the Director.

Related to Intake #007972-18 and Intake #015258-18:

Personal Support Worker (PSW) #116 indicated, to Inspector #554, that they witnessed an alleged incident of staff to resident abuse, on a specific identified date, involving resident #023. PSW #116 indicated that they observed PSW #119 providing specific grooming to resident #023, at the nursing station; PSW #116 indicated that resident #023 was heard screaming and indicated that the resident told PSW #119 to stop more than once. PSW #116 indicated that PSW #119 continued to cut resident #023's fingernails, and indicated that this interaction continued for ten minutes or more. PSW #116 indicated that other residents and a visitor witnessed this alleged staff to resident abuse. PSW #116 further indicated that PSW #119 did not provide a bath to resident #011, on the specified date, as per their planned care.

PSW #116 indicated that they reported the staff to resident abuse, verbally to the Administrator-Director of Care (ADM-DOC) a number of days after the abuse occurred. PSW #116 indicated that they verbally reported the incident to the ADM-DOC, but they also provided the ADM-DOC with a written statement the date it was reported.

ADM-DOC indicated, to Inspector #554, that they are aware of the reporting requirements under section 24. On two separate dates during interviews with Inspector #554, the ADM-DOC indicated that they were not aware of any alleged incident of staff to resident abuse occurring on the specified date, involving PSW #119 towards resident #011 and resident #023.

PSW #105, who is a representative of the union for the PSW's at the long-term care home, indicated to Inspector #554 during an interview, that they were present, on a specified date, when PSW #116 verbally reported an alleged incident of staff to resident abuse, involving resident #023, to the ADM-DOC. PSW #105 further indicated that PSW #116 also provided the ADM-DOC with a written statement regarding the alleged abuse.

On a specified date, ADM-DOC indicated that they 'now recall having a meeting with PSW #116, on a specified date', ADM-DOC indicated that during the meeting, PSW #116 did 'mention' an incident of alleged abuse by PSW #119 towards residents #011 and #023. ADM-DOC indicated this allegation was not reported to the Director.

The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse or a resident by anyone has occurred, immediately report the suspicion and information upon which it was based to the Director. [s. 24. (1)]

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 by ensuring that a person who had reasonable grounds to suspect that, abuse of a resident by anyone, had or may occur, immediately report the suspicion and information upon which it was based to the Director, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the written staffing plan, for the nursing and personal support services program, provides for a staffing mix that is consistent with residents' assessed care and safety needs; sets out the organization and scheduling of staff shifts; promotes continuity of care by minimizing the number of different staff who provide nursing and personal support services to each resident; includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work; and gets evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Substitute Decision Maker (SDM) #033, #034, #035 and #036 indicated, to Inspector #554 on four separate dates, that the long-term care home is 'frequently short staffed'. All SDM's interviewed indicated that it is their belief that resident care and services are being affected.

Personal Support Worker (PSW) #119, and Registered Nurse (RN) #112 indicated, to Inspector #554 on two specified dates, that the long-term care home is 'frequently short staffed'; PSW #119 and RN #112 indicated that when there are situations when staff cannot come to work, the licensee is 'only partially filling scheduled shifts'. PSW #119, and RN #112 indicated that the direction from the licensee, specifically the direction of the Administrator-Director of Care (ADM-DOC), is that when there is a staffing absence, 'the scheduled twelve hour shift is only to be replaced for eight of the twelve hours'. PSW #119 and RN #112 indicated that when they ask the ADM-DOC or the On-call Manager how they are to provide resident's with the assessed care and safety needs during situations when staff cannot come to work, and when only eight hours of a twelve hour shift is being replaced, they (the staff) are told to 'do the best you can'.

On a specified date, the ADM-DOC provided Inspector #554 with a copy of the 'Nursing Schedule' and 'Staff Call-In Sheet' templates. ADM-DOC indicated, that both, the nursing schedule and staff call-in sheet templates, are considered the licensee's written staffing plan.

The written staffing plan, provided by the ADM-DOC, was reviewed with Inspector #554. The written staffing plan fails to provide the following:
- does not provide a staffing mix based on resident's assessed care and safety needs;
- does not include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work;

- nor does it speak to evaluation and annual updates in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The ADM-DOC indicated that same day nursing and personal support services staff absences are only being 'partially filled to avoid staff lay-offs and prevent cut-backs in purchasing of nursing supplies'. ADM-DOC indicated nursing staff are expected to work together on a daily basis, including situations when staff cannot come to work. ADM-DOC indicated 'it is up to the staff to communicate and to determine how resident care will get done'.

The ADM-DOC indicated that they have been the ADM-DOC for eighteen months, and prior to that was Interim DOC since 2015. ADM-DOC indicated that the written staffing plan has not been evaluated or updated while they have been employed by Hyland Crest.

The licensee has failed to ensure that the written staffing plan, for the nursing and personal support services program, provides for a staffing mix that is consistent with residents' assessed care and safety needs; includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work; and gets evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 31. (3)]

2. The licensee failed to ensure there is a written record of each annual evaluation of the staffing plan, including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made, and the date that those changes were implemented.

During an interview the ADM-DOC indicated, to Inspector #554, that it is their role to oversee the operations of the long-term care home. ADM-DOC indicated they have been in the role, as the ADM-DOC for past eighteen months and prior to that time, they were the Interim DOC, assuming that role in 2015. ADM-DOC indicated that they are unable to locate any documentation specific to the licensee's staffing plan being evaluated annually, and further indicated that they have not participated in an annual evaluation, since 2015.

The licensee has failed to ensure there is a written record of each annual evaluation of the staffing plan, including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those

changes were implemented. [s. 31. (4)]

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 by ensuring that the written staffing plan, for the nursing and personal support services program, provides for a staffing mix that is consistent with residents' assessed care and safety needs; sets out the organization and scheduling of staff shifts; promotes continuity of care by minimizing the number of different staff who provide nursing and personal support services to each resident; includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work; and gets evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents have their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within forty-eight hours of admission and of acquiring, in the case of new items.

On a specified date, during the initial tour of the long-term care home, Inspector #554 observed the following:

- Tub/Shower Room (in a specified resident home area) – two urinals were observed on the toileting assist bars, both urinals were unlabelled. A comb, two sets of nail clippers, and an 'Old Spice' stick deodorant were observed on the counter-top vanity in the room. The comb contained two colour shades of hair. The items identified were observed to be used and were unlabelled.

- Tub/Shower Room (in a specified resident home area) – a brush, a comb, and a set of nail clippers were observed on the counter-top vanity and/or on the tub side table in the room. The brush contained two colour shades of hair. The items were observed to be used and were unlabelled.

- Communal Residential Washroom (in a specified resident home area) – a urinal was observed on the toileting assist bar, and was unlabelled. The urinal contained traces of yellowish-brown fluid.

- Tub/Shower Room (in a specified resident home area) – a brush containing hair was observed on the counter-top vanity, the brush was unlabelled.

- Tub/Shower Room (in a specified resident home area) – a brush, a comb, and an 'Gillette' razor with blade were observed on the counter-top vanity in the room. All items were observed to be used and unlabelled.

On a specified date, four sets of nail clippers were observed on side of the sink, in the tub/shower room on a specified resident home area. The nail clippers were observed to be unlabelled. There was a brush on the counter-top vanity in the tub/shower room, the brush contained hair, and was unlabelled.

Personal Support Worker (PSW) #110, and PSW #113 indicated, to Inspector #554 on two separate dates, that personal items, such as brushes, combs, nail clippers and deodorant are to be labelled for individual resident use.

Registered Nurse (RN) #112, who is a Charge Nurse in the home, indicated, to Inspector #554 on a specified date, that personal items, such as brushes, combs, nail clippers and deodorant are to be labelled and are designated for use by individual residents. RN #112 indicated that PSW's are responsible for labelling personal items, but indicated that all staff can label personal care item when it is identified as being unlabelled.

The Administrator/Director of Care indicated, to Inspector #554 during an interview, that all personal care items are to be labelled for individual resident use.

The licensee has failed to ensure that residents have their personal items labelled within forty-eight hours of admission and of acquiring in the case of new items. [s. 37. (1) (a)]

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 by ensuring that residents have theiur personal items, including personal aids such as dentures, glasses and hearing aids, labelled within fourty-eight hours of admission and in the case of new items, or acquiring, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity,

including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Inspection was initiated for resident #014 as a result of a stage 1 RQI inspection trigger that identified the presence of a Stage 3 or 4 alteration in skin.

Review of the clinical records for resident #014 including the progress notes for a specified period of time, was completed by Inspector #623. The records identified the presence of an alteration in skin in an identified area on a specified date as documented by RPN #115. There is no indication that a skin assessment was completed at that time. One month later there is further documentation by RPN #106 to indicate that the initial identified area had worsened and the resident now required the use of therapeutic interventions. The following day, RPN #106 completed a skin and wound assessment in Point Click Care (PCC) that identified resident #014 previously had an alteration in skin in a specific identified area, and had been using a specific intervention during the day. During RPN #106's assessment the area had worsened to a stage 4 or unstagable alteration in skin.

RPN #115 was not available for interview during the inspection.

On a specified date, during an interview with Inspector #623, RPN # 106 indicated that resident #014 currently had an alteration in skin in an identified area. RPN #106 indicated that when an alteration in skin is identified, an assessment is to be completed in PCC and a progress note is written. If the alteration in skin is a stage 2 or greater, the physician is to be notified. The SDM should also be notified of any new or worsening skin alteration. RPN #106 indicated that there were no documented skin and wound assessments for resident #014's specific identified area, when the alteration in skin was initially identified. RPN #106 indicated that an assessment was not completed for resident #014 until one month later, when the alteration in skin was identified to be a stage 4 or unstageable wound.

On a specific date and time during an interview with Inspector #623, the Admin/DOC indicated that the licensee's expectation is when an alteration is skin is identified, a skin assessment would be completed in PCC when a wound is identified

The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a

member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspection was initiated for resident #014 as a result of a stage 1 RQI inspection trigger that identified the presence of a Stage 3 or 4 pressure ulcer.

Review of the clinical records for resident #014 including the progress notes for a specified period of time, was completed by Inspector #623. The records identified the presence of an alteration in skin in an identified area on a specified date as documented by RPN #115. There is no indication that a skin assessment was completed at that time. One month later there is further documentation by RPN #106 to indicate that the initial identified area had worsened and the resident now required the use of therapeutic interventions. The following day, RPN #106 completed a skin and wound assessment in Point Click Care (PCC) that identified resident #014 previously had an alteration in skin in a specific identified area, and had been using a specific intervention during the day. During RPN #106's assessment the area had worsened to a stage 4 or unstagable alteration in skin.

Review of the skin and wound assessments and the skin and wound progress notes for resident #014 was completed by Inspector #623. There were no documented weekly assessments for the specific identified area during specific identified time periods.

On a specific date and time, during an interview with Inspector #623, RPN # 106 indicated that resident #014 currently has an alteration in skin in a specific identified area. The RPN indicated that the identified area is to be assessed daily and signed for in the MAR, the eMAR will prompt the nurse to write a progress note which should include an assessment of the identified area. RPN #106 indicated that a weekly skin assessment is not scheduled for resident's with identified altered skin integrity, a detailed assessment should be documented with each dressing change.

On a specific date and time, during an interview with Inspector #623, RPN #104 indicated that resident #014 has an alteration in skin in a specific identified area,l that requires a daily dressing. RPN #104 when the dressing is signed as completed in the eMAR, there is a prompt to write a progress note, but this is usually not done. RPN #104

indicated that there is no identified weekly skin assessment scheduled for any resident that had altered skin integrity. RPN #104 indicated that they do not complete weekly assessments for residents with altered skin integrity.

On a specific date and time, during an interview with Inspector #623, the Admin/DOC indicated that the licensee's expectation is that a skin assessment will be completed in PCC when an alteration in skin is identified. The eMAR will then be created for the identified area, to ensure that a skin assessment is completed with each dressing change and a progress note is written. The expectation is that wounds are reassessed at least weekly but the Admin/DOC is aware that this is not happening.

The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [s. 50. (2) (b) (iv)]

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 by ensuring that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, and that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #14: 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 failed to ensure that strategies are developed and implemented, where possible, for each resident demonstrating responsive behaviours.

Related to Intake #007972-18:

Personal Support Worker (PSW) #116 indicated, to Inspector #554, that they witnessed an alleged incident of staff to resident abuse, on a specified date, involving resident #023. PSW #116 indicated that they observed PSW #119 providing specific grooming to resident #023, at the nursing station; PSW #116 indicated that resident #023 was heard screaming and indicated that the resident told PSW #119 to stop more than once. PSW #116 indicated that PSW #119 continued to provide the specific grooming to resident #023, and indicated that this interaction continued for a few more minutes. PSW #116 indicated that other residents and a visitor witnessed this alleged staff to resident abuse.

Substitute Decision Maker (SDM) #036, who is the SDM for another resident, indicated, to Inspector #554 on a specific date, that they witnessed the specific staff to resident incident, involving resident #023.

The clinical health record, for resident #023, was reviewed, by Inspector #554. The following was documented:

The written care plan was reviewed by Inspector #554.

PSW #119 and Registered Nurse (RN) #112 indicated, to Inspector #554 on two separate dates, that resident #023 was known to be resistive to care, and indicated that if resident #023 exhibits a responsive behaviour the intervention in place is 'to leave the resident and reapproach'.

PSW #119 indicated that they had provided specific grooming to resident #023 on the specific identified date. PSW #119 indicated that while providing the grooming to resident #023, the resident became resistive and began screaming; PSW #119 indicated that resident #023 told them to 'stop'. PSW #119 indicated that they continued to provide the specific grooming resident #023.

The licensee has failed to ensure that strategies were implemented, for each resident demonstrating responsive behaviours, specifically resident #023 on January 07, 2018. [s. 53. (4) (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 by ensuring that strategies are developed and implemented, where possible, for each resident demonstrating responsive behavoiurs, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that concerns or recommendations of the Resident Council are responded to in writing within ten days of receiving the advice.

Resident #021, who is the President of the Resident's Council, indicated, to Inspector #554 on a specified date, that the licensee does not respond to concerns or recommendations of the Resident Council, within ten days of receiving them. Resident #021 indicated that the written responses, regarding their concerns are not provided to the Council until the next meeting. Resident #021 indicated that Resident Council meetings are held monthly. Resident #021 further indicated that the responses provided, by the licensee, do not consistently address the concerns forwarded by the Resident's Council.

The Resident Council meeting minutes for a specific identified period of time were reviewed by Inspector #554. The review failed to provide support that concerns or recommendations raised by the Council, were being responded to by the licensee within ten days of receiving them.

Manager of Life Enrichment, liaison to the Resident's Council, indicated to Inspector #554 on a specific date, that they take the minutes for the Resident's Council. Manager of Life Enrichment indicated that concerns or recommendations of the Council are documented in the meeting minutes, and forwarded to the Administrator-Director of Care (ADM-DOC), or the identified manager for review and response. The Manager of Life Enrichment indicated that the ADM-DOC or the identified manager is to respond within ten days; Manager of Life Enrichment indicated that they read the written response, by the licensee or designate, to Council members at the next monthly meeting.

Manager of Life Enrichment indicated that they were aware that concerns or recommendations of the Resident Council had to be responded to within ten days, but indicated not being aware that the written responses had to be actually provided to the Resident Council during that same time frame. Manager of Life Enrichment indicated that they had been the liaison, to the Resident's Council for the past eighteen months.

The licensee has failed to ensure that concerns or recommendations of the Resident Council are responded to in writing within ten days of receiving them. [s. 57. (2)]

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 by ensuring that concerns or recommendations of the Resident Council are responded to in writing within ten days of receiving them, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff receive training on the policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

During this inspection, Inspector #554 inspected upon three alleged and or witnessed incidents of staff to resident abuse.

Administrator-Director of Care (ADM-DOC) indicated, to Inspector #554 on a specified date, that all staff hired received training related the licensee's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities, and or direct care of residents.

Related to Intake #007469-18:

Personal Support Worker (PSW) #108 witnessed an incident of staff to resident verbal-emotional abuse on a specified date; Critical Incident Report was submitted.

PSW #108 started with the licensee on a specific identified date three months prior to the incident.

The ADM-DOC indicated that they are responsible to ensure that all staff hired receive training specific to the licensee's policy to promote zero tolerance of abuse and neglect of residents. ADM-DOC indicated that newly hired PSW's are provided with a 'Personal Support Worker Orientation Package' when they are hired, and indicated that the new hire is directed to read the package, sign and date the package and return the package to the ADM-DOC.

PSW #108 was not available for an interview during this inspection.

ADM-DOC indicated that they were uncertain if PSW #108 completed the required training prior to starting the role as a personal support worker' as their personnel file was missing the signed orientation package for PSW #108. ADM-DOC indicated that they are responsible to ensure the personnel files were complete.

The licensee has failed to ensure that staff received training on the licensee's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities. [s. 76. (2) 3.]

2. The licensee failed to ensure that all staff have received retraining annually related to, the Resident's Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and whistle-blowing protections.

During this inspection, Inspector #554 inspected upon three intakes #007469-18, #007972-18 and #015258-18, specific to alleged and or witnessed incidents of staff to resident abuse:

Administrator-Director of Care (ADM-DOC) indicated, to Inspector #554 on a specified date, that all staff receive annual retraining related the Resident's Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and whistle-blowing protections. ADM-DOC indicated that all staff complete the annual retraining by 'logging onto the Surge-Learning (the licensee's web-based training site) and completing the assigned modules'. ADM-DOC indicated that all staff are required to have the annual training completed prior to December 31, of each year.

ADM-DOC provided Inspector #554 with the statistical report for Surge-Learning for a specified year, which included the licensee's zero tolerance of abuse and neglect policy , and training related to resident's bill of rights, power imbalance and abuse prevention. ADM-DOC indicated to Inspector #554 on a specified date, that only 94% of staff had received annual retraining prior to December 31 of the specified year.

ADM-DOC (from Highland Woods) who was onsite and covering for ADM-DOC, for Hyland Crest on two identified dates, indicated, to Inspector #554 that all staff are expected to complete the required annual retraining between annually during the calender year. ADM-DOC indicated that it is the responsibility of the ADM-DOC to review the Surge-Learning in November to ensure staff have completed the required training and to follow up with any staff who have not yet completed the required training. ADM-DOC indicated 'it is the responsibility of the ADM-DOC to ensure all staff have completed the annually retraining by December 31 each year'. ADM-DOC indicated that six employee's had not completed the required training by December 31, of the identified year.

The has licensee failed to ensure that all staff had received retraining annually related to, the Resident's Bill of Rights, the home's policy to promote zero tolerance of abuse and

neglect of residents, the duty to make mandatory reports under section 24, and whistle-blowing protections in the identified year. [s. 76. (4)]

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 by ensuring that staff receive training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities, as well as by ensuring that all staff have received retraining annually related to, the Resident's Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and whistle-blowing protections, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Resident's Council in developing and carrying out the satisfaction survey, and in acting on its results.

Resident #021, who is the President of the Resident's Council, indicated, to Inspector #554 on a specified date, that the licensee had not sought the advice of the Resident's Council in the development and/or carrying out the annual Satisfaction Survey, and/or in acting on the survey results.

The Resident Council meeting minutes, for a specified time period, were reviewed by Inspector #554. The review failed to provide support that the licensee sought the advice of the Resident's Council in developing and carrying out of the annual satisfaction survey, and in acting on its results.

Manager of Life Enrichment, liaison to the Resident's Council, indicated, to Inspector #554 on a specified date, that they did not recall the licensee seeking the advice of the Resident's Council in the development and/or carrying out the annual satisfaction survey.

Manager of Life Enrichment indicated no recall of the satisfaction survey being discussed at the Resident Council meetings.

The Administrator-Director of Care (ADM-DOC) indicated, to Inspector #554 on a specified date, that the advice of the Resident's Council was not sought in the development and/or carrying out of the annual satisfaction survey, and or in acting on its results. The ADM-DOC indicated that the current annual satisfaction survey has not yet been initiated.

The licensee failed to seek the advice of the Resident's Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

2. The licensee failed to ensure that the results of the satisfaction survey were documented and made available to the Resident's Council in order to seek the advice of the Council about the survey.

Resident #021, who is the President of the Resident's Council, indicated, to Inspector #554 on a specified date, that the licensee had not provided the Resident's Council the results of the annual satisfaction survey, nor had they sought the advice of the Council related to the same.

The Resident Council meeting minutes, for a specified period of time, were reviewed by Inspector #554. The review failed to provide support that the results of the annual satisfaction survey were made available to the Council.

Manager of Life Enrichment, liaison to the Resident's Council, indicated, to Inspector #554 on a specified date, that they did not recall the results of the annual satisfaction survey being made available to the Council.

The Administrator-Director of Care (ADM-DOC) indicated, to Inspector #554 on a specified date, that the results of the annual satisfaction survey had been documented and had been shared with the Family Council, but indicated the results had not made available to the Resident's Council.

The licensee has failed to ensure that the results of the satisfaction survey were made available to the Resident's Council in order to seek the advice of the Council about the survey. [s. 85. (4) (a)]

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 by ensuring that they seek the advice of the Resident's Council in developing and carrying out the satisfaction survey, and in acting on its results, as well as by ensuring that the results of the satisfaction survey were documented and made available to the Resident's Council in order to seek the advice of the Council about the survey, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within twelve hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Related to Intake #007469-18:

The Administrator-Director of Care (ADM-DOC) submitted a Critical Incident Report to the Director on a specified date, regarding an allegation of staff to resident verbal-

emotional abuse, involving Personal Support Worker (PSW) #116 towards resident #026. The alleged abuse incident occurred five days earlier.

The ADM-DOC indicated, to Inspector #554, that the SDM for resident #026 was not notified of that alleged verbal-emotional abuse incident until five days following the alleged incident. ADM-DOC indicated that they notified resident's SDM.

The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within twelve hours upon becoming aware of the alleged abuse of resident #026. [s. 97. (1) (b)]

2. The licensee failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within twelve hours upon becoming aware of any alleged, suspected or witnessed abuse or neglect of a resident.

Related to Intake #007972-18 for a Critical Incident Report related to an alleged staff to resident verbal abuse, and Intake #015258-18 for a Critical Incident Report related to an alleged staff to resident abuse:

Personal Support Worker (PSW) #116 indicated, to Inspector #554, that they witnessed an alleged incident of staff to resident abuse, on a specified date, involving resident #023. PSW #116 indicated that they observed PSW #119 providing specific grooming for resident #023, at the nursing station; PSW #116 indicated that resident #023 was heard screaming and indicated that the resident told PSW #119 to stop more than once. PSW #116 indicated that PSW #119 continued to provide the grooming to resident #023, and indicated that this interaction continued for a number of minutes more. PSW #116 indicated that other residents and a visitor witnessed this alleged staff to resident abuse.

PSW #116 indicated they reported the alleged abuse incident to Registered Practical Nurse (RPN) #133 on the date that it occurred, and to the Administrator-Director of Care (ADM-DOC) some time later.

Registered Nurse (RN) #112 indicated, to Inspector #554, that resident #023 had a designated SDM in place.

The clinical health record, for resident #023, were reviewed a specified period of time. The review failed to provide documentation to support that resident #023's SDM was notified of the alleged staff to resident abuse incident which PSW #116 indicated as

occurring on an identified date.

RPN #133 was unavailable for an interview during this inspection.

The ADM-DOC indicated, to Inspector #554, that RPN #133 should have notified resident #023's SDM when the alleged staff to resident abuse was first reported.

ADM-DOC indicated that they became aware of the alleged staff to resident abuse until some time after the incident occurred. ADM-DOC indicated they had not notified resident #023's SDM of the abuse allegation. ADM-DOC indicated being uncertain if resident #023's SDM had been notified to date of the alleged staff to resident abuse.

The licensee has failed to ensure that resident #023's SDM was notified within twelve hours of becoming aware of any alleged, suspected or witnessed abuse of the resident. [s. 97. (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 by ensuring that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within twelve hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area of a medication cart, ii. that is secure and locked

During the RQI inspection on a specified date and time, Inspector #623 discovered the medication cart unlocked and unattended in a specific identified resident area. RN #125 was observed to be in an adjacent room administering medications. The inspector observed the cart for approximately five minutes before RN #125 returned. Resident #032 was also standing near the unattended medication cart, outside of the adjacent room at the time of the observation.

On a specific date and time, during an interview with Inspector #623, RN #125 indicated that they did not lock the medication cart when they left the cart unattended, to administer medications to a resident in the adjacent room. RN #125 indicated that the expectation is that the medication cart is to be locked when the nurse is not with the cart.

June 20, 2018, during an interview with Inspector #623, the Admin/DOC indicated that the expectation is that the medication cart is to be locked at all times when it is not in use and when the RN/RPN is not in attendance.

The licensee failed to ensure that drugs are stored in an area or a medication cart, that is secure and locked. [s. 129. (1) (a)]

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 by ensuring that drugs are stored in an area of a medication cart that is secured and locked, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure staff participate in the infection prevention and control program.

On June 11, 2018, during the initial tour of the long-term care home, Inspector #554 observed the following:

- A specific identified room - was observed to have signage on door indicating 'droplet precautions' were in place. The yellow caddy intended to hold/store personal protective equipment (PPE) contained gloves, gowns, and masks (surgical type style). The sign on the door indicated that 'eye protection must be worn within two metres of the resident'. The PPE caddy did not contain eye wear (e.g. goggles, or face shield). The identified room is a shared resident room.

On a specified date, Personal Support Worker (PSW) #102 and PSW #103 were observed, by Inspector #554, entering the specific identified resident room without donning PPE, and closed the door to the room. The yellow PPE caddy on the door of the identified room contained gloves, gowns and masks. Approximately ten minutes later, PSW #102 and PSW #103 were observed exiting the room with resident #126. When asked by Inspector #554, which resident in the identified room was in isolation/precaution, PSW #103 indicated that resident #126 was in 'droplet isolation'.

PSW #102 and PSW #103 indicated that they had not worn gowns, masks and/or eye protection while caring for resident #126. PSW #102 and PSW #103 indicated that PPE's are required when caring for a resident identified as being in isolation. Both PSW's indicated that 'staff do not normally wear goggles or an eye shield unless the resident is coughing'. PSW #103 indicated resident #137 was 'in isolation as the resident had been vomiting'.

Infection Prevention and Control / Occupation Health Nurse (IPAC/Occ. Health Nurse) indicated, to Inspector #554, that they were the 'lead' for infection prevention and control for HHHS (Haliburton Highlands Health Services). IPAC/Occ. Health Nurse indicated that staff have been providing training specific to the risk of transmission, isolation/precautionary measures, and PPE. IPAC/Occ. Health Nurse indicated that staff are expected to follow isolation/precautionary signage, and don appropriate PPE when caring for a resident identified as being in isolation or under precautions.

The licensee has failed to ensure that staff participate in the infection prevention and control program, specifically the availability and identified usage of PPE when a resident has been identified as being in isolation and/or precautions.

2. The licensee failed to ensure staff participate in the infection prevention and control program.

On a specified date, a staff member was observed by Inspector #554 wearing gloves as they walked in the hallways on a specific identified RHA. The same staff member was observed wearing the same gloves as they assisted a resident in a wheelchair, keying in the entry/exit code (meg lock system), touching the doorway handle of the fire doors exiting the RHA, and entering the service hallways leading to the acute care side of the facility. (Note: staff member was not observed again during this inspection)

On a specified date, maintenance staff were observed by Inspector #554 wearing gloves as they entered a specific RHA, entered the severy (kitchen area). Approximately five minutes later, the maintenance staff exited the severy and left the RHA. During this observation, the maintenance staff were observed touching door handles to the severy, keying in the entry/exit code (meg lock system), and touching the doorway handle of the fire doors entering/exiting the RHA.

On a specified date, PSW #119 was observed by Inspector #554 wearing gloves while doing the AM (morning) nourishment cart, on a specified RHA. PSW #119 was observed

pushing the nourishment cart, opening/closing doors of resident rooms, entering and exiting resident rooms, assisting resident's with beverages, using a key to open the severy door, touching uncovered straws, and assisting a resident with a snack, all while wearing the same gloves.

PSW #119 indicated, to Inspector #554 during an interview, that they routinely wears gloves while doing the nourishment cart, and that they wear the same gloves during this entire task. PSW #119 indicated that they have had training specific to the use of hand hygiene and appropriate use of PPE.

Infection Prevention and Control / Occupation Health Nurse (IPAC/Occ. Health Nurse) indicated, to Inspector #554, that they were the 'lead' for infection prevention and control for HHHS (Haliburton Highlands Health Services). IPAC/Occ. Health Nurse indicated that staff have been providing training specific to the risk of transmission, appropriate use of PPE, and hand hygiene, they also indicated that the licensee follows the PIDAC (Provincial Infectious Diseases Advisory) best practice guidelines (BPG), specifically "Just Clean Your Hands". IPAC/Occ. Health Nurse indicated that staff are remove gloves following resident care, and are not to wear gloves in the hallways.

The Administrator/Director of Care indicated, to Inspector #554, that staff were not to wear gloves while in the hallways, and or while doing the nourishment cart.

The licensee has failed to ensure that staff participate in the infection prevention and control program, specifically related to hand hygiene and appropriate use of gloves. [s. 229. (4)]

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 by ensuring that staff participate in the infection prevention and control program, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the residents personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

During the RQI mandatory medication observation the following was observed:

On a specific date and time, an observation of resident #028 medication administration was conducted by Inspector #623. When RPN #104 went to administer the medications, they were observed to walk away from the medication cart while leaving the computer screen open and resident #028's personal health information visible. The RPN walked down the hallway to administer the medication to an area where the cart was no longer visible. RPN #104 was then observed to prepare medications for resident #027 who was seated in a resident home area. Once the medication was prepared, RPN #104 turned their back to the medication cart and walked away, leaving the computer screen closed half way but still visible, with resident #027's personal health information visible on the screen. There were 15 resident's observed in the lounge as well as staff and visitors at

that time.

On a specified date, during an interview with Inspector #623, RPN #104 indicated that the lap top on the medication cart does not have a privacy screen, when RPN #104 leaves the medication cart to administer a medication, they are supposed to close the lid half way to protect the privacy of the residents personal information but they don't always do it.

During an observation on a specific date and time, Inspector #623 discovered the medication cart parked outside of a specific resident home area, resident #031's personal health information was visible on the computer screen and the RN was not present at the cart. RN #125 was observed to be in an adjacent room administering medications. Resident #032 was standing near the medication cart at the time of the observation.

On a specified date, during an interview with Inspector #623, RN #125 indicated that they did not lower the computer screen to conceal resident's personal health information, when they left the cart to administer medications to a resident in an adjacent room today. RN #125 indicated that the expectation is that the computer screen is to be locked or closed to protect the residents personal health information. RN #125 indicated that they did not know why the computer screen was left open and visible to anyone who passed by, they just didn't lock the screen.

On a specified date, during an interview with Inspector #623, the Admin/DOC indicated that the expectation is that the computer screen on the medication cart is to be locked anytime that the RN/RPN walks away from it, to protect the personal health information of the resident's. The DOC indicated that all of the screens all have a locking feature and should be used.

The licensee failed to ensure that the personal health information within the meaning of the Personal Health Information Protection Act, 2004, is kept confidential in accordance with the Act, for residents #027, #028 and #031. [s. 3. (1) 11. iv.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care must be based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

Related to Intake #007469-18:

The Administrator-Director of Care (ADM-DOC) submitted a Critical Incident Report to the Director, on a specified date, specific to an alleged incident of staff to resident verbal/emotional abuse. The CIR indicated that the alleged abuse occurred five days prior, and involved resident #026.

The Administrator-Director of Care (ADM-DOC) indicated, to Inspector #554, that during the licensee's investigation of the alleged incident, it was determined that resident #026 was calling for staff to assist the resident to bed. ADM-DOC indicated that 'normally' resident #026 is taken to their room following a specific meal, Personal care is provided and is assisted into bed by two staff using a transfer devicet. ADM-DOC indicated that the investigation identified that Personal Support Worker (PSW) #116 assisted resident #026 to their room, but did not provide resident's 'routine personal care'.

PSW #103 indicated, to Inspector #554, that resident #026's preference is to settle to bed daily around a specified time. PSW #103 indicated that PSW's would take resident #026 to their room, provide personal care and transfer resident into bed using the assistance of two staff and a transfer device.

The clinical health record, for resident #026, was reviewed by Inspector #554. The plan of care, specifically the written care plan currently in place, fails to identify resident #026's sleep patterns and preferences.

Registered Nurse (RN) #112 indicated, to Inspector #554, that the plan of care does not routinely identify each resident's sleep patterns and preferences. RN #112 indicated that the 'sleep patterns and preferences are only identified the plan of care if there has been

a resident or family concern raised'.

The licensee has failed to ensure that the plan of care must be based on an interdisciplinary assessment of the resident's sleep patterns and preferences. [s. 26. (3) 21.]

2. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

Related to Intake #003632-18:

The Administrator-Director of Care (ADM-DOC) submitted a Critical Incident Report to the Director, on February 11, 2018, specific to an alleged incident of staff to resident verbal/emotional abuse. The CIR indicated that the alleged abuse which occurred on February 07, 2018, involved resident #030 and resident #037.

Substitute Decision Makers (SDM) #033 and #034 indicated, to Inspector #554 on June 19, and June 20, 2018, that resident #037's condition had been gradually deteriorating, and indicated that resident #037 needed more rest due to low energy. SDM's indicated that they had requested that resident #037 be allowed to sleep in until a specified time and be permitted to have breakfast in bed. SDM's indicated that this was also the request voiced by resident #037. SDM's indicated that a contributing factor to the alleged staff to resident abuse incident was that nursing staff were inconsistent with allowing resident #037 'to sleep in till a specified time'.

The clinical health record, for resident #037, was reviewed by Inspector #554, for a specified period of time.

The health record provides details that resident #037's health had deteriorated. A progress note, written by registered nursing staff on a specified date, indicates that SDM's #033 and #034 had requested that resident #037 'remain in bed for breakfast due to resident's frail condition'. The written care plan (dated a number of days later) fails to identify planned care specific to resident #037's sleep pattern and preferences.

Registered Nurse (RN) #112 indicated, to Inspector #554, that resident #037's health condition had deteriorated, and that resident required bed rest periodically. RN #112 indicated that they could not recall if the SDM's for resident #037 had requested for resident to remain in bed until a specified time. RN #112 indicated that the written plan of

care doesn't normally include sleep pattern and references, unless there has been a concern brought forth.

The ADM-DOC indicated, to Inspector #554, that plan of care for each resident should be based on an interdisciplinary assessment of the resident's sleep patterns and preferences, and that such should be clearly documented in the written care plan for each resident.

The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences, specific to resident #037. [s. 26. (3) 21.]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a report to the Director was made within ten days of the becoming aware of an alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

Related to Intake #007972-18, and #015258-18:

Personal Support Worker (PSW) #116 indicated, to Inspector #554, that they witnessed an alleged incident of staff to resident abuse, on a specified date, involving resident #023. PSW #116 indicated that they observed PSW #119 providing specific personal grooming to resident #023, at the nursing station, PSW #116 indicated that resident #023 was heard screaming and indicated that the resident told PSW #119 to stop more than once. PSW #116 indicated that PSW #119 continued to groom resident #023, and indicated that this interaction continued for a number of minutes more. PSW #116 indicated that other residents and a visitor witnessed this alleged staff to resident abuse.

PSW #116 indicated they had reported the alleged staff to resident abuse to the Administrator-Director of Care (ADM-DOC) a number of days later. PSW #116 indicated that another staff was present when they reported the alleged abuse to ADM-DOC.

PSW #105 indicated, to Inspector #554, that they were present in a meeting with PSW #116, when PSW #116 reported the alleged abuse, involving PSW #119 and resident #023, to the ADM-DOC, and another management staff.

The ADM-DOC indicated, to Inspector #554, that they were aware of the alleged abuse, involving PSW #119 and resident #023, on a specified date. ADM-DOC indicated that PSW #116 indicated that the alleged abuse occurred several days prior. The ADM-DOC indicated that they were aware that a Critical Incident Report (CIR) was to be submitted to the Director within 10 days of the licensee becoming aware of an alleged abuse incident. ADM-DOC indicated that a CIR had not been submitted to the Director as of the date of this inspection.

The licensee has failed to ensure that a report was made to the Director within ten days of the becoming aware of an alleged, suspected or witnessed incident. [s. 104. (2)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

During the mandatory medication IP, a review of the medication incidents that occurred in the home during the look back period was completed. The following was identified:

On a specified date, RN #125 administered a specific medication - 1 tablet at a specified time to resident #029. Resident #029's orders indicated the same specific identified medication was to be administered three times daily - routinely at specified times as well as a different specified medication - 1 tablet at a different specified time.

Review of the progress notes indicated that RN #125 documented on a specified date, that at a specified time resident received a specific identified medication, 1 tab, at at a specific time in error. Was to receive a different specific identified medication as per eMAR. Recent changes to routine medication orders. Resident has received a specific identified medication three times daily and is familiar with this medication, will monitor resident closely overnight due to increased dose received today.

During an interview with Inspector #623, RN #125 indicated that they recall the medication incident that occurred on a specified date, involving resident #029, but could not recall the details surrounding it. RN indicated that the resident had previously been receiving the identified medication at a specified time. RN #125 was uncertain how the incorrect medication was given.

During an interview with Inspector #623, the ADM-DOC indicated that the licensees expectation was that medications are administered to residents as prescribed.

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber, when resident #029 received a specific identified medication at bedtime from RN #125, when a different medication was ordered. [s. 131. (2)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

While completing the mandatory medication IP, during the RQI, the following was identified.

On a specified date, RN #125 administered a specific medication to resident #029 at a specified time. The medication orders for resident #029 indicated that a different specific medication was prescribed to be administered at the specified time.

The medication incident report form indicated that the action taken: Monitor resident closely overnight - receives medication routinely three times daily, so not new to the resident and they tolerate it well.

Review of the clinical records - progress notes, for resident #029 indicated the following:

On a specified date and time, RN #125 documented that resident #029 received a specific medication at a specific time in error. Resident #029 was to receive a different medication as per eMAR. Resident has received the specific medication routinely and is familiar with this medication, will monitor resident closely overnight due to increased dose received today. Medication Incident report completed, faxed to National Pharmacy with copy of MD order. Copy also submitted to DOC.

There is no further documentation to indicate any monitoring or assessment of resident #029, was completed immediately following the identified medication incident. Review of the clinical records including the medication incident report, risk management report and progress notes, fails to indicate that the resident's SDM was notified of the medication incident.

On a specified date, during an interview with Inspector #623, RN #125 indicated that all persons that were notified of the incident, should have been documented on the medication incident form as well as in the progress notes. RN #125 was unable to recall if the SDM for resident #125 was notified and confirmed that there is no documentation to support that they SDM was notified. RN #125 indicated that when the incident was discovered, the immediate action taken was documented that resident #029 will be monitored closely overnight, there was no documented assessment of the resident. RN #125 indicated that they chart by exception, if there is no documentation then there was no negative effect on the resident. RN #125 indicated that they were the RN in charge overnight following the medication incident involving resident #029.

On a specified date, during an interview with Inspector #623, the ADM-DOC indicated that the expectation of the licensee is that when a medication incident occurs, an assessment of the resident is completed and documented, which would include immediate actions as well as any additional monitoring that is required. The ADM-DOC also indicated that the SDM is to be notified when a medication incident occurs.

The licensee failed to ensure that the medication incident involving resident #029 was documented, together with a record of the immediate actions taken to assess and

maintain the resident's health, and reported to the resident's SDM. [s. 135. (1)]

2. The licensee has failed to ensure that:
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed
(b) corrective action is taken as necessary, and
(c) a written record is kept of everything required under clauses (a) and (b).

While completing the mandatory medication IP, during the RQI, the following was identified:

A medication incident occurred on a specified date where resident #029 received a specific identified medication at a specified time when a different medication was ordered.

A review of the medication incident report identified that the pharmacy follow-up, the corrective action to prevent further occurrence and the signature of the pharmacy have no documentation to indicate that the incident was reviewed and analyzed. A review of the meeting minutes from the two most recent, Pharmacy & Therapeutics (P&T) meeting does not indicate that medication incidents were reviewed.

On a specified date, during an interview with Inspector #623, the Admin/DOC indicated that medication incidents are supposed to be reviewed at the P&T meeting quarterly with the physicians, pharmacy and the Admin/DOC. The Admin/DOC indicated that the last P&T meeting was held at the end of a specific month, and the medication incidents for the quarter, at Hylandcrest, were not reviewed because the medical director was not available to attend. The quarterly meeting that was scheduled before that there was just the pharmacy and the Admin/DOC. Medication incidents were not discussed during that meeting because there were no physicians at the meeting. The Admin/DOC indicated that there was a meeting held in the quarter prior, but the DOC was unable to locate the minutes from that meeting for review.

The licensee has failed to ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed, corrective action is taken as necessary, and a written record is kept of everything. [s. 135. (2)]

Issued on this 7th day of January, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SARAH GILLIS (623), KELLY BURNS (554)
Inspection No. / No de l'inspection :	2018_591623_0010
Log No. / No de registre :	009732-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 14, 2018
Licensee / Titulaire de permis :	Haliburton Highlands Health Services Corporation 7199 Gelert Road, Box 115, HALIBURTON, ON, K0M-1S0
LTC Home / Foyer de SLD :	Hyland Crest 6 McPherson Street, P.O. Box 30, Minden, ON, K0M-2K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	April DeCarlo

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To Haliburton Highlands Health Services Corporation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee must be compliant with s. 15. (2) (a) of the LTCHA.

Specifically the licensee must:
1. Ensure that the home, furnishings and equipment are kept clean and sanitary, which is to include the carpets within communal areas and resident rooms. A written record must be kept of all cleaning that is completed in the home.

Grounds / Motifs :

1. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

During the initial tour of the long-term care home, the carpeting in the home was observed, by Inspector #554, to be stained. The stained carpeting was located throughout the resident home areas, specifically in residential hallways, and in the resident communal areas, adjacent to an identified area. The staining on the carpets was more extensive on a specific resident home area. A noticeable odour was also present as Inspector #554 entered the identified resident home areas.

While touring the long-term care home, stained carpeting was also observed, from the hallway, in specific identified resident rooms, both located on the same specific identified area of the home.

Stained carpeting in residential hallways, resident communal areas, and in specific identified resident rooms, was observed to be stained on a number of specified dates. Stained carpeting was also observed, by Inspector #554, in another specific identified resident room on a number of identified dates.

Resident #021, indicated to Inspector #554 on a specific date, that the carpets in the home are of concern, and need professional cleaning or replacement.

Substitute Decision Maker (SDM) #036 and SDM #033 indicated to Inspector #554 on different identified dates, that they have concerns with the cleanliness of the carpets in the long-term care home.

Housekeeping Aide (HSK) #111 indicated, to Inspector #554 on a specific date, that the carpeting in the long-term care was approximately eighteen years old. HSK #111 indicated that the stained carpeting has been an area of concern for some time, and has been brought up at Environmental Staff Meetings by staff to managers, specifically departmental manager and to the Administrator, on more than one occasion. HSK #111 indicated that the 'extractor' used for carpet cleaning is constantly breaking down, and indicated that 'staff are told by management that there is no money to replace the extractor'. HSK #111 indicated that the carpeting in residential hallways, common areas (e.g. lounges) and in resident rooms is 'not consistently cleaned as housekeeping staff lack the time, and the equipment'. HSK #111 indicated that the 'staining on the carpet is from every day wear and tear, food and beverages being spilled on the carpets and from residents at times urinating on the carpets'. HSK #111 indicated it is their belief that the carpeting in the home is a contributing factor to the odour in the long-term care home.

Director of Environmental Services and Plant Operations (DESPO) indicated, to Inspector #554 on a specific date, that they have been in the role for a specific period of time, and has identified that carpeting in the long-term care home are 'extensively stained, and in need of cleaning'. DESPO indicated that housekeeping staff do 'spot clean' carpets as needed. DESPO indicated that they believe the carpets in the long-term care home are to be cleaned yearly, but indicated they do not know that last time carpeting in the home had been cleaned. DESPO indicated that a quote has been requested by an external service provider, but indicated that they were unsure of the status of the quote at

this time, and indicated that the approval for such costs would come from the Director of Facility and Projects (DESPO's manager) and the Chief Financial Officer. DESPO indicated that it is their belief that the carpets in the long-term care home contributes to the odour in both resident home areas.

The Director of Facility and Projects indicated, to Inspector #554 on a specific date, that at this time no quotes and/or approval had been received for the carpets in the long-term care home to be cleaned.

The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary, specifically the carpeting in the long-term care home.

The severity of this issue was determined to be a level 2 as there is minimal harm to residents. The scope of the issue was level 3 - widespread, as during this inspection the carpeting within the LTCH, was identified by inspector #554 to be heavily stained within common areas (lounges) and in individual resident rooms on all resident home areas. Nursing staff, housekeeping staff, maintenance staff, the DESPO, residents and families all indicated that the stained carpeting was a contributing factor to the odours within the LTCH. The home had a level 4 compliance history as despite MOH action, ongoing non-compliance continued for s. 15. (2) (a). (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 12, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

(b) is on at all times;

(c) allows calls to be cancelled only at the point of activation;

(d) is available at each bed, toilet, bath and shower location used by residents;

(e) is available in every area accessible by residents;

(f) clearly indicates when activated where the signal is coming from; and

(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s.17.(1) of the LTCHA.

Specifically the licensee must:

1. Ensure that the home is equipped with a resident-staff communication and response system is every area accessible by residents, including the outdoor resident accessible areas of the LTCH. The Licensee shall ensure that all resident accessible areas are equipped with a resident-staff communication and response system that meets the legislative requirements under O. Reg. 79/10, s. 17.

Grounds / Motifs :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, is on at all times; allows calls to be cancelled only at the point of activation; is available in every area accessible by residents; that it clearly indicates when activated where the signal is coming from; and in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

During the initial tour of the long-term care home (LTCH), it was observed, by Inspector #554, that four specific separate identified home areas, did not have a resident-staff communication and response system available.

Personal Support Worker (PSW) #113, Registered Nurse (RN) #112, Maintenance Staff #122, and the Administrator-Director of Care (ADM-DOC) indicated to Inspector #554, that the specific identified areas are considered resident accessible areas.

RN #112, Maintenance Staff #122, and the ADM-DOC indicated that the door bells located in the specific identified home areas are not part of the resident - staff communication and response system.

Maintenance Staff #122 indicated that the audible sound of the door bells, to alert staff that residents or others need assistance, are not calibrated.

During interviews with RN #122, Maintenance Staff #122, and the ADM-DOC, as well as observations it was concluded that the door bells in use for specific identified resident home areas, do not comply with O. Reg. 79/10, s. 17 (1) (b) (c), (f) and (g).

The DESPO, and the ADM-DOC indicated that they were not aware that outside resident accessible areas were required to have resident-staff communication and response system available.

The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, is on at all times; allows calls to be cancelled only at the point of activation; is available in every area accessible by residents; that it clearly indicates when activated where the signal is coming from; and in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents, as the specific identified outdoor areas are considered resident space, and are used for outdoor enjoyment of the residents residing in the home. This area of non-compliance poses a risk to residents safety and affects every resident residing in the long-term care home. The scope

of the issue was a level 2 as a pattern throughout the home was identified. The home had a level 4 compliance history as they had on-going non-compliance with the section of the LTCHA.

(554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 12, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 87 (2) (d) of the LTCHA.

The licensee shall prepare, submit and implement a written plan for achieving compliance with O. Reg. 79/10, s. 87 (2) (d) of the LTCHA.

The plan must include, but is not limited, to the following:
1. Develop a policy and/or procedure for addressing incidents of lingering offensive odours;
2. Implement the policy and/or procedure when lingering offensive odours have been identified;
3. Provide training on the policy and/or procedure for addressing incidents of lingering offensive odours with staff, ensuring staff are aware of how and when issues specific to lingering offensive odours will be communicated with key personnel, including housekeeping staff and management, in an effort to reduce and or eliminate odours within the LTCH;
4. Keep record of the educational content of the training and the staff that receive the training;
5. Develop a monitoring system to ensure that the policy and/or procedure has been implemented when incidents of lingering offensive odours are identified, and that staff are complying with the licensee's policy.

Please submit the written plan quoting log number and LTC Homes Inspector, to the MOHLTC.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

During the initial tour of the long-term care home by Inspector #554, a lingering offensive odour was noticeable as you entered both the upper and lower resident home areas. The odour was worse on the lower level resident home area. The odour resembled urine.

Inspector #554, noted a similar odour in a residential hallway on a specified home area, the odour was increasingly offensive as the Inspector walked past

and entered a specific identified room that is shared by two residents.

The lingering offensive odour was noted to be present over the course of the entire inspection, throughout all resident home areas, and as Inspector #554, walked by and/or entered a specific identified resident room.

On a specified date, two visitors were observed walking in a residential hallway in a specific identified resident home area (same hallway as the identified resident room), and were overheard by Inspector #554 to comment on the smell.

Personal Support Worker (PSW) #110 indicated, to Inspector #554 on a specified date, that both residents residing in the specific identified resident room require total care by staff and were incontinent. PSW #110 indicated that the odour in the identified resident room is frequently present, and indicated that the odour has been worsening over time. PSW #110 indicated that the odour 'smells like urine'. PSW #110 indicated that they assume that housekeeping staff and the Administrator are aware of the odour issue, as the odour is not a new issue in the home.

Housekeeping Aide (HSK) #111 indicated, to Inspector #554 on a specified date, that there has been an odour issue in the long-term care home for some time. HSK #111 indicated that some resident rooms, and common areas (e.g. lounges/sitting areas) 'smell like urine' as there are residents residing in the home who are known to 'urinate inappropriately in areas' within in the home. HSK #111 indicated that the specific identified resident room often smells of urine, as both residents were incontinent and exhibited responsive behaviours. HSK #111 indicated that other issues contributing to odours in the home are, that food and beverages are often spilled on the carpeting and that spills are not immediately cleaned up by staff. HSK #111 indicated it is their belief that the stained/soiled carpeting in the home is another contributing factor to the odour in the long-term care home.

HSK #111 indicated that other than daily cleaning, using a daily disinfectant, and an aerosol spray air freshener there is no other policy and or procedure for addressing lingering offensive odours in the long-term care home. HSK #111 indicated that odour concerns have been brought forth at Environmental Staff Meetings.

The Director of Environmental Services and Plant Operations (DESPO) indicated, to Inspector #554 on a specified date, that they were aware that the long-term care home has a lingering offensive odour, and indicated that the odour 'hits you as you enter specific identified areas' of the home. DESPO indicated that it is their belief that the carpets in the home are contributing to the odour.

DESPO indicated that they were uncertain if there was a policy or procedure in place for addressing lingering offensive odours, but indicated that they would check with the Administrator, covering the long-term care home on that specified date. DESPO indicated to Inspector #554 later that day, that the Administrator (covering the home) indicated that there is was no policy or procedure for addressing lingering offensive odours in the home.

The licensee has failed to ensure that procedures were developed and/or implemented for addressing incidents of lingering offensive odours in the long-term care home.

The severity of this issue was determined to be a level 2 as there is minimal harm to residents. The scope of the issue was level 2 as the lingering offensive odour emitting from a specific identified area were detected during all dates of the inspection. The lingering offensive odour was detected not only within the shared room, within the specific identified resident home area hallway, and as you approached the entry to the specific resident communal area. The home had a level 3 compliance history as one or more related non-compliance had been issued in the last three years for O. Reg. 79/10, s. 87 (2) (d) of the LTCHA. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 15, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # /
Ordre no : 004

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,

(a) the home, furnishings and equipment are kept clean and sanitary;

(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and

(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee must be compliant with s. 15 (2) (c) of the LTCHA.

The Licensee shall prepare, submit and implement a written plan for achieving compliance with LTCHA, 2007, s. 15 (2) (c).

The plan must include, but is not limited, to the following:

1. Develop a plan to address identified maintenance concerns addressed in this inspection report, specifically stained ceiling tiles, repairs required to balconies and courtyards, non-functioning door bells, leaking roof, and burnt out or defective lights, the plan shall include when such repairs and/or replacement will rectified, time frames for repair and or replacement, and who will oversee the repair and or replacement. This plan shall be in detailed and in writing.
2. Develop and implement a systematic maintenance procedure that will ensure that the home, furnishings and equipment are maintained in a safe condition, and in a good state of repair. The procedure shall include routine inspections of the home, furnishings and equipment, and what action is to be done and by whom. Should the home, furnishings and equipment be assessed and or identified as needing repair and or replacement, there should be a process in place to immediately address concerns, and to rectify such concerns without delay. The procedure shall be detailed and in writing.
3. Implement a procedure for communication of required maintenance concerns for all staff and management. This procedure shall be detailed and in writing.

Please submit the written plan, quoting log number and LTC Homes Inspector, MOHLTC, by email.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that the home, furnishings, and equipment are maintained in a safe condition and in a good state of repair.

Related to Intake Log #007017-18

During the initial tour of the long-term care home (LTCH), the following was observed by Inspector #554:

In a specified Resident Home Area (RHA)
- Ceiling tiles: observed to have brownish staining on two ceiling tiles in the hallway outside of specific identified resident rooms; one ceiling tile was observed stained outside of another specific identified resident room.

- Balcony Patio Area #1: wooden floor boards, on the balcony-sitting area, were observed to be uneven and lifting in areas, screws on the floor boards were observed absent in areas. One resident was observed sitting outdoors on the balcony-sitting area.
- Balcony Patio Area #2: wooden floor boards were observed uneven and lifting in areas; the paint on the floor boards was observed chipped, there was weeds and grass extending from the hillside onto the decking. A sign on the door to the balcony area indicated 'balcony temporarily closed'. The door to the balcony was locked.
- Specific identified Resident Room: ceiling tiles observed stained, four ceiling tiles were observed off, exposing pipes and wiring in the ceiling, and the carpet was observed stained. The resident room was not in use. The resident who had been residing in the identified room had been relocated temporarily to another location within the LTCH due to the roof leaking into their room.
- Resident Staff Communication and Response System (main box): observed to have duct tape across the system, and a plastic cup taped to the volume control.

Specific identified RHA
- Carpeting: heavily stained carpets were observed in the main common area, adjacent to nursing station and dining room. This was observed on both RHA's. Carpeting was also observed stained in a specific identified resident.
- Walls: observed to have dry wall putty visible on walls throughout the hallways, to the right as you enter the identified RHA.
- Commode: observed to have one side arm missing (left side). The commode was observed in the tub-shower room, in a specific identified RHA.
- Door Bells: observed to be non-functioning on both of the exit/entry doors of the secured courtyard. This is a resident accessible area. Residents were observed using the courtyard at the time of this observation.
- Ceiling Lights: observed non-functioning in the hallway, outside of two specific identified resident room. Ceiling lights remained non-functioning on a number of

specified dates during the inspection.
- Outdoor Patio Area: weeds and grass was observed extending into the outdoor patio area from the hillside. Overgrown weeds and grass were observed growing between the patio stones. This patio was accessible to residents.

The maintenance binder was reviewed by Inspector #554 covering the period of four months, there is no mention in the maintenance binder of the above identified areas needing repair and or replacement.

Two Substitute Decision Makers, for specific identified residents residing in the LTCH, indicated, to Inspector #554 on two separate identified dates, that it is their belief the home is not being maintained, and is in need of repair.

Housekeeping Staff (HSK) #111 indicated, to Inspector #554 on a specific date, that carpeting in the LTCH was heavily stained as they, the housekeeping staff, did not have the equipment, specifically a carpet extractor, to maintain the carpets. HSK #111 indicated that the carpet extractor is frequently broken and that housekeeping staff were told in a staff meeting that there was 'no money to fix the extractor'. HSK #111 indicated that there is one carpet extractor in the LTCH, but such is not adequate to keep up with the work required within the LTCH.

Maintenance Staff #122 indicated, to Inspector #554 on a specific date, that the ceiling tiles in the LTCH are stained due to the roof leaking. Maintenance Staff #122 indicated that the roof of the LTCH has been leaking for some time, and indicated that the roof had been leaking prior to the current DESPO's arrival seven months ago, and indicated that on a specified date two residents had to be relocated due to the water from the roof leaking into their rooms. Maintenance Staff indicated that the maintenance workers have been told to patch the roof but indicated that such repairs are 'bandage solutions' and indicated they, the maintenance staff have no roofing experience. Maintenance Staff #122 indicated that the balconies in the LTCH have been in need of repair for years. Maintenance Staff #122 indicated that the main box for the resident-staff communication and response system had been broken since an identified date, indicating at times the volume is so low staff can't hear resident's ringing for assistance. They indicated that external contractors had been in to look at the system and had indicated that the system is obsolete and there are no parts

available to repair it. Maintenance Staff #122 indicated they had been told 'there is no money available for repair or replacement' of the balconies and or the resident-staff communication and response system. Maintenance #122 indicated being unaware that the door bells in the courtyard were non-functioning. Maintenance Staff #122 indicated we try to keep up to what needs repairing but at times difficult as they cover maintenance on the hospital side too.

The Director of Environmental Services and Plant Operations (DESPO) indicated, to Inspector #554 on a specific date, the following:
- that they were aware the carpets in the LTCH are heavily stained, and indicated that such maybe contributing to the odours in the home. DESPO indicated that they are aware that one of the carpet extractors is broken. DESPO indicated that there is no plan in place to repair and or replace the carpet extractor as of this time. DESPO indicated they have been told by their supervisor, the Director of Facility and Projects and/or the Director of Finance that there no funds to repair and or replace the carpet extractor.
- that the ceiling tiles in the home are stained due to the roof leaking. DESPO indicated that the roof of the LTCH has been leaking since the 'first thaw' in January 2018. DESPO indicated that there has been external service providers in to look at the roof but as of this time, that they have not received quotes and or approval for repairs of the roof. DESPO indicated being aware that two residents had been relocated due to the roof leaking into their rooms. In a second interview DESPO indicated they had been told that the roof had been leaking prior to a specified date, but they were not entirely sure as they had just begun the role of DESPO seven months ago.
- being aware that the identified balcony area, is in need of repair. DESPO indicated not being aware that the balcony had been closed. DESPO again indicated being told that there was no funds to repair the balcony as of this time. DESPO indicated being unaware of uneven or lifting boards on the other identified balcony facing. DESPO indicated that the upkeep of the balconies and or outdoor sitting areas should be maintained, but indicated being unsure whose responsibility it was to remove overgrown weeds and/or grass from such areas.
- being unaware that door bells in an identified area were non-functioning. DESPO indicated being unaware that the courtyard and or balcony had door bells.

On a specified date, three more ceiling tiles were observed to be stained, and

appeared 'wet' outside of two specific identified resident rooms; two ceiling tiles observed stained outside of a third identified resident room; four ceiling tiles stained outside of a specific identified resident communal area; and two ceiling tiles were observed stained outside of the specified RHA lounge, adjacent to the balcony. These eleven ceiling tiles were not observed to be stained during the initial tour seven days prior.

The Director of Facility and Projects indicated, to Inspector #554 on a specified date, being aware that the roof in the LTCH needed repair or replacement, and also indicated being unsure how long the leaking roof had been an issue. The Director of Facility and Projects indicated being aware that resident's residing in the home had been relocated due to the roof leaking, but indicated being unsure if residents remain dislocated. The Director of Facility and Projects indicated that request for contract had been recently placed in the paper, but contractors had until a specified date to visit the site and bid on the contract. The Director of Facility and Projects indicated further that the hope was to have the roof repaired by end of a specified date, but indicated that such approvals are beyond their scope.

The Administrator indicated, to Inspector #554 on a specified date, being aware that the roof of the LTCH was in need of repair, and indicated that two resident's had been relocated, within the LTCH, due to water leaking into their rooms. Administrator indicated that as of this time, a third resident has had to be relocated within the home due to the roofing issues. The Administrator indicated having not heard of when the roof will be repaired, and or when the three identified residents can return to their assigned rooms. The Administrator indicated that the roof in the LTCH had been leaking prior to a specified date, and prior to the current DESPO taking on their role.

The Administrator indicated being aware that the balconies/outdoor sitting areas RHA's needed repair. The Administrator indicated there is no plan in place to repair and or replace these areas as of this time. The Administrator indicated that they were not told that the specific identified balcony, had been closed. The Administrator indicated that the areas are for resident use, and indicated some resident's had voiced concern with not being able to use the one identified balcony. The Administrator indicated being unaware that the door bells on courtyard doors are non-functioning.

The Administrator, who is to oversee the operations of the LTCH, indicated not being kept abreast of needed repairs in the LTCH as the DESPO does not report directly to them, but reports to the Director of Facility and Projects, and that such communications is not shared.

The DESPO and the Administrator indicated that the LTCH is maintained in a safe condition and in a good state of repair, for the safety and well-being of the residents residing in the LTCH.

On the final day of this on-site inspection, residents assigned to specific identified resident rooms remained dislocated from their assigned rooms. The required repairs and/or replacement, identified by Inspector #554, on a specified date, remain a concern.

The licensee has failed to ensure that the home, furnishings, and equipment are maintained in a safe condition and in a good state of repair.

The severity of this issue was determined to be a level 2 as there is minimal harm to residents. The scope of the issue was level 3 - widespread, as during this inspection many areas within the LTCH, were identified by inspector #554 to be in a state of disrepair including common areas and in individual resident rooms on all resident home areas. The home had a level 4 compliance history as despite MOH action, ongoing non-compliance continued for s. 15. (2) (a). (554)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 15, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 14th day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sarah Gillis

Service Area Office /
Bureau régional de services : Central East Service Area Office