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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 23, 2015	2015_323130_0026	H-003245-15	Resident Quality Inspection

Licensee/Titulaire de permis

NIAGARA INA GRAFTON GAGE HOME OF THE UNITED CHURCH
413 Linwell Road St. Catharines ON L2M 7Y2

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

INA GRAFTON-GAGE HOME
413 Linwell Road St Catharines ON L2M 7Y2

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

GILLIAN TRACEY (130), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 10, 11, 14, 15, 16, 17, 18, 21, 22, 23 and 24, 2015.

The following inspections were conducted simultaneously with this RQI: Follow-ups: H-001377-14 related to CO#002, s. 78 (2), H-001379-14 related to CO#004, reg. 52 (2), H-001382-14 related to CO#007, r. 261, H-001378-14 related to CO#3, reg. 49 (2), H-001376-14 related to CO#001 and s. 8 (3), H-001380-14 related to CO#005, reg. 101 (2), CI inspections H-001034-14 and H-001987-15 and complaint inspections H-001775-14, H-002331-15, H-002657-15 and H-003093-15.

During the course of this inspection, the home was toured, resident care, medication administration and meal service was observed, residents, staff and families were interviewed, clinical records, employee files, home's investigation notes and relevant policies and procedures were reviewed.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Resident Care (DRC), Manager of Finance, recreation staff, dietary staff, housekeeping staff, registered staff, personal support workers (PSWs), residents and families.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **4 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 101. (2)	CO #005	2014_250511_0010	508
O.Reg 79/10 s. 229. (10)	CO #006	2014_250511_0010	130
O.Reg 79/10 s. 261. (1)	CO #007	2014_250511_0010	130
O.Reg 79/10 s. 49. (2)	CO #003	2014_250511_0010	508
O.Reg 79/10 s. 52. (2)	CO #004	2014_250511_0010	508
LTCHA, 2007 S.O. 2007, c.8 s. 78. (2)	CO #002	2014_250511_0010	130

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	Legendé 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one Registered Nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

A review of the Registered Staffing Schedule for September 2015, identified a patterned absence of Registered Nurses (RN) that were filled by Registered Practical Nurses (RPN). From September 7 - 20, 2015, there were at least 29 shifts of 42 that there was no RN present and on duty in the home. The DRC identified they did not have an RN for these regular scheduled shifts and these shifts were replaced by an RPN. The DRC confirmed the home has been unsuccessful in recruiting Registered Nurses despite their efforts. (Inspector #130) [s. 8. (3)]

Additional Required Actions:

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

WN #2: 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).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out, (a) the planned care for the resident and (b) the goals the care was intended to achieve.

A) According to the clinical record resident #009 was admitted on an identified date in 2015. The DRC confirmed that the written plan of care, including the planned care for the resident and the goals the care was intended to achieve, was not developed until some time later in 2015. (Inspector #130) [s. 6. (1) (b)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A) The Minimum Data Set (MDS) Resident Assessment Instrument (RAI) Assessment

completed for resident #012 indicated that restraints/devices were used daily to prevent chair rising. However, the written plan of care indicated the resident did not require restraints/devices. The DRC confirmed this information. The written plan was not based on the assessment of the resident. (Inspector #130)

B) The MDS RAI assessments completed on three identified dates in 2015, indicated the resident was continent of bowel. Front line staff interviewed confirmed the resident was continent of bowel. However, the written plan of care revised on the second identified date in 2015, indicated the resident was very occasionally incontinent of bowel. The written plan of care was not based on the assessment of the resident. (Inspector #130)

C) Resident #003 was coded as being independent in a wheelchair for mobility on an identified date, 2015. Two months later in 2015, resident #003 was coded as requiring extensive assistance of staff for mobility. The DRC indicated that the resident would require intermittent assistance with their mobility.

A review of the resident's current plan of care indicated that the resident was independent with wheelchair under the mobility focus. It did not indicate that the resident would intermittently require extensive assistance from staff as coded in the most recent MDS assessment.

It was confirmed by the DRC that the resident's current plan of care was not based on the most recent assessment and the resident's needs and preferences. (Inspector #508) [s. 6. (2)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) The plan of care for resident #009 indicated the resident required a specific safety intervention when in their wheelchair. On two identified dates in 2015, the resident sustained falls without injury, from their wheelchair. Fall incident reports, staff and the DRC confirmed the safety intervention was not in use as required in the plan of care. (Inspector #130).

B) On an identified date in 2015, resident #012 was observed in their wheelchair with an intervention in place. The resident was unable to remove the intervention when asked. The DRC observed the intervention and confirmed the resident was not suppose to have it and verified this was not a required intervention in their written plan of care. Care was

not provided as specified in the plan. (Inspector #130)

C) Resident #501 was cognitively impaired and had identified responsive behaviours.

The resident's plan of care for managing the resident's behaviour included, the intervention for staff to not express their anger or impatience verbally or with physical movements. It also directed staff not to argue or condemn the resident.

On an identified date in 2014, the resident was agitated and staff put the resident to bed to try to calm the resident down. The resident was calling out and screaming that they had to go to the bathroom. The resident was attempting to get out of bed.

A review of the clinical record indicated that RPN #001, on duty, went into the resident's room and told the resident that they would have to wait and put the resident back into the bed when the resident was trying to get up. The resident attempted to hit RPN #001 and RPN #001 caught their hand resulting in an injury.

RPN #001 then documented in the resident's clinical record that the resident demonstrated specific responsive behaviours after sustaining the injury. RPN #001 also documented that the resident was assisted back to bed after care was provided, yet they were still unhappy as they continued demonstrate responsive behaviours.

It was confirmed through review of the documentation in the resident's clinical record that the interventions were not followed and that care set out in the plan of care was not provided to the resident. (Inspector #508) [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan of care was no longer necessary.

A) Resident #014 had a fall in 2015, and was transferred to hospital due to their injuries. The resident required intervention for the injury and was admitted to the hospital. The resident was re-admitted to the home eight days later and was initially on bedrest with the exception of physiotherapy.

A review of the resident's plan of care indicated that the resident was currently on bedrest; however, the resident had been observed multiple times during this inspection sitting up in their wheelchair.

An interview with the DRC in 2015, confirmed that the written plan of care did not reflect the current needs of the resident and that the plan had not been revised. (Inspector #508)

B) According to the written plan of care, resident #007 was independent with all aspects of toileting, which included transfer on/off toilet, cleansing self, changing product and adjusting clothes); however, a progress note in 2015, indicated the resident was disallowed to use the public washroom because of their need for assistance. The DRC confirmed that due to a specific impairment the resident did not leave the public washroom in a clean condition. The DRC confirmed that the resident's written plan of care should be revised to include assistance with toileting.

The resident's plan of care was not reviewed and revised when the resident's care needs changed. (Inspector #130) [s. 6. (10) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident and (b) the goals the care was intended to achieve, that care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan of care is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) On an identified date in 2014, it was reported to the DRC that resident #503 had felt threatened by RPN #001. The resident's family member had been approached by witnesses to an incident that occurred between resident #503 and RPN #001. The resident was having difficulty sitting in an upright position independently in their wheelchair while eating. RPN #001 advised the resident in a very loud voice that if the resident couldn't sit up in the wheelchair independently they would be transferred to the "feeding table".

The resident was upset and embarrassed as this was overheard by other residents in the dining room and the resident did not require staff assistance. The resident was upset about the threat as the resident did not require that level of staff assistance. The resident was embarrassed as this occurred in a public setting and later told a family member that they were feeling depressed about the threat.

The resident was also upset about how RPN #001 was treating them when administering their medications. The resident preferred to take their medication after taking a bit of food. RPN #001 would tell the resident "You're taking the pills and you're taking them now", even if the resident had not had any food yet. During this inspection, many concerns had been brought forth to the Inspectors about how RPN #001 would yell at residents and demand that they take their pills when the RPN administered them.

During an interview with the family member, it was confirmed that the resident had felt threatened, embarrassed and upset about how RPN #001 had treated them.

After several discussions with the DRC regarding how RPN #001 was treating residents, it was confirmed by the DRC, that residents were not protected from abuse by anyone, including resident #503. (Inspector #508)

B) On an identified date in 2014, resident #007 was exhibiting symptoms and requested to be sent to the hospital for an assessment. RPN #001 on duty documented the resident's request for treatment due to specific symptoms. According to RPN #001's documentation, the resident's request was denied based on the RPN's assessment and after discussion with the resident's POA.

The clinical record confirmed that on identified date in 2015, a short time after the request for treatment was denied, tests revealed the resident required treatment intervention for their ongoing symptoms.

The DRC was interviewed by Inspector #130 and verified the resident was competent and capable of making their own decisions. The DRC confirmed the resident's request to go to hospital should have been respected.

On the specified date in 2014, resident #007 was neglected by staff. (Inspector #130).

C) During the stage one resident interviews, resident #007 reported that while they were in the dining room, their table mate had offered them an item to take back to their room, which they accepted. A staff member came over and demanded to know where the item was, so the resident advised them that they had put it in their bag to take it to their room. The resident reported a staff member held their arm to the table while a second staff searched their bag and removed it. The resident stated they were so upset by the action that they reacted in a specific manner towards staff. The resident stated they were then removed from the dining room and told by RPN #001 that residents like them go to jail for things like that. They stated the incident left them feeling scared. Three staff interviewed recalled witnessing RPN #001 yelling at the resident on the identified date in 2014. One staff reported hearing RPN #001 yelling a specific statement to the resident and witnessing RPN #001 grabbing the item away from the resident. Two others reported hearing RPN #001 yelling at the resident over the item.

On the specified date in 2014, resident #007 was not protected from abuse. (Inspector #130)

D) Resident #501 had cognitive impairment and identified responsive behaviours. It had been reported to the Inspectors that in 2014, resident #501 was demonstrating responsive behaviours when staff attempted to provide specific care to the resident.

The resident's plan of care directed staff to be cognizant of not invading the resident's personal space. It also directed staff not to express their anger or impatience verbally or physically towards the resident as this would worsen responsive behaviours.

On this identified date in 2014, RPN #001 was witnessed being physically rough with resident #501 and forced the resident to receive care. It was reported that the resident was kicking and screaming as RPN #001 stripped the resident's clothing off. RPN #001 was witnessed saying to the resident "see I told you…you are going to have your [care]".

It was confirmed through interviews conducted on two identified dates in 2015, that resident #501 was not protected from abuse by RPN #001. [s. 19. (1)]

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. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
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).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,

ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and

cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

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 every resident had the right to have his or her participation in decision-making respected.

A) On an identified date in 2014, resident #007 was exhibiting specific symptoms and requested to be sent to the hospital for an assessment. RPN #001 on duty recorded a progress note that confirmed the resident's symptoms; however, the resident's request was denied. RPN #001 advised the resident they could wait until the following week. The resident stated they couldn't wait that long before being assessed, but RPN #001 still denied their request to go the hospital. RPN #001 called the resident's POA and informed them of resident's "demand" to be sent to hospital via ambulance. POA agreed with the RPN that it wasn't an emergency and instructed staff not to send them regardless of their wishes unless staff felt it necessary. RPN #001 advised the resident of the POA's instructions. The resident was not sent to hospital despite repeated requests.

The clinical record confirmed that days later, tests revealed the resident had symptoms, which required treatment.

The DRC was interviewed by Inspector #130 and verified the resident was competent and capable of making their own decisions. The DRC confirmed the resident's request to go to hospital should have been respected.

Resident #007's right to participate fully in making decisions was not respected. (Inspector #130). [s. 3. (1)]

2. The licensee failed to ensure that every resident was properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

A) According to the clinical record, resident #007 had a known diagnosis, which caused specific symptoms. On a specified date in 2014, RPN #001 observed the resident approach the public washroom. RPN #001 documented a progress note which read that the resident was reminded of the rules that they must use their own washroom. The note also stated that the resident immediately began crying and was portered to their own room. RPN #001 documented in a progress note that the resident was upset with staff at lunch today due to staff suggesting they use their own washroom instead of the public washroom this morning at breakfast. Resident agreed to do so, but was upset with staff as the incident resulted in an episode of incontinence.

The DRC was interviewed and confirmed that although the resident was encouraged to use their own washroom, the resident should not have been prohibited from using the public washroom.
Resident #007 was not cared for in a manner consistent with their needs. (Inspector #130)

B) Resident #501 had cognitive impairment and identified responsive behaviours. The physician ordered a routine anti-psychotic to manage the resident's behaviours and also ordered additional doses to be administered when needed.

A review of resident #501's clinical record indicated that the resident demonstrated responsive behaviours on the evening and night shift on a specified date in 2014. Staff put the resident to bed to reduce the responsive behaviour which was ineffective as the resident attempted several times to climb out of the bed.

The resident was screaming that they had to go to the bathroom. RPN #001 went into the resident's room and put the resident back into bed and informed the resident who was cognitively impaired, that they would have to wait until another staff member could

assist. The resident continued to scream out that they had to go to the bathroom.

RPN #001 indicated in the clinical record that during this interaction with the resident, the resident attempted to hit RPN #001 and RPN #001 caught the resident's fist and again put them back into the bed. As a result, the resident sustained an injury which was bleeding.

It was confirmed during a review of the Medication Administration Record for that date in 2014, that although the resident had demonstrated responsive behaviours for over six hours RPN #001 did not administer the resident's PRN (as needed) medication to alleviate the behaviour.

It was confirmed after review of the resident's clinical record that resident #501's rights were not fully promoted and respected when the resident was not cared for in a manner consistent with the resident's needs. (Inspector #508) [s. 3. (1) 4.]

3. The licensee failed to ensure that every residents' right to 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, was fully respected and promoted.

A) During the medication observation at 1200 hours on September 18, 2015, it was observed that registered staff discarded the medication pouches, containing resident names and medication orders, with the regular garage. The registered staff confirmed this was routine practice. Residents' personal health information was not kept confidential in accordance with the Act. (Inspector #130) [s. 3. (1) 11. iv.]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Resident #010 was identified at risk for falls and would frequently climb out of bed, resulting in the resident falling. The resident was using two half bed rails while the resident was in bed for bed mobility.

The resident's bed rails had been removed from the resident's bed on an identified date 2015, when staff identified the bed rails as a risk for bed entrapment. The resident's family requested that the resident's bed rails be put back on the bed as the resident used them for bed mobility. Months later in 2015, the bed rails were put back on to the resident's bed.

A review of the resident's clinical record indicated that the resident had not been assessed and the bed system had not been evaluated at any time for the use of the bed rails.

It was confirmed by the DRC that the resident was not assessed and the resident's bed system was not evaluated in accordance with evidence based practices, to minimize the risk to the resident. (Inspector #508) [s. 15. (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 to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #6: 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,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who were dependent on staff for repositioning were repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load.

A) Resident #014 was observed by the Inspector on an identified date in 2015, sitting up in their wheelchair in their room at a specified time calling out to the Inspector and PSWs walking by.

The Inspector approached the resident in the resident's room and the resident who was unable to communicate verbally pointed to the bed.

Staff indicated that the resident had been toileted at a specified time and had to stay up until after lunch. The DRC indicated that this was the request of the family.

During this observation, the resident sat in their wheelchair until the Inspectors requested that staff toilet and reposition the resident as the resident had been up in their wheelchair for an excess of over three hours. The resident had not been repositioned for a number of hours and was calling out to go to bed.

A review of the resident's clinical record indicated that the resident developed an area of impaired skin integrity to a specified area on an identified date in 2015 and a second area to another location two weeks later.

The resident's plan of care indicated that the resident required staff assistance for mobility and also directed staff to reposition the resident every two hours.

It was confirmed by staff that the resident had not been repositioned for an excess of three hours. (Inspector #508) [s. 50. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents who are dependent on staff for repositioning are repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, to be implemented voluntarily.

WN #7: 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 that staff participated in the implementation of the infection prevention and control program.

A) On September 10, 2015, it was observed in the tub room that there were three razors and four combs lying on the counter that were not labeled to identify who they belonged to. It was also observed that there were two sets of nail clippers, not labeled. An interview with a PSW that had been working in the tub room indicated that the razors and the combs should have been labeled to identify who they belonged to. The PSW also indicated that the nail clippers are not labeled as they are used by multiple residents and disinfected at the end of each shift.

An interview with the DOC indicated that the nail clippers are used on multiple residents; however, the nail clippers are to be disinfected after each use, not at the end of the shift. The DOC confirmed that the staff were not complying with the infection prevention and control program and that the nail clippers should have been disinfected after each use. (Inspector #508) [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 to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #8: 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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

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

The home's policy titled: Abuse-Free Environment, C-10-03-03, reviewed May 27, 2015 indicated: "2. The Ministry of Health, Long Term Care Division requires that all staff report any act of abuse towards a resident. NIGGV (Niagara Ina Grafton Gage Village) requires that all abuse be reported".

A) On an identified date in 2013, the DRC and the CEO received a written report of alleged witnessed abuse by RPN #001 towards resident #500, on a specified date. The DRC verified this was not the first complaint received regarding this identified staff member and confirmed the allegation of abuse was not reported to the Director. (Inspector 130)

B) On an identified date in 2014, dietary and nursing staff reported witnessing RPN #001 "yelling" at a resident in the dining room. The DRC confirmed she was not aware of the incident and that staff had not reported the incident to her. Staff did not comply with the policy to report all allegations of abuse. (Inspector #130)

The home's policy titled: Abuse-Free Environment, C-10-03-03, reviewed May 27, 2015, outlined actions that would constitute abuse, including emotional and psychological abuse.

During this inspection, it was reported to the Inspectors that RPN #001 was abusive to residents, including resident #501 and resident #503.

On an identified date in 2014, it was reported by witnesses that there had been an incident between RPN #001 and resident #503. RPN #001 was observed by others to be yelling at the resident in a threatening tone. Resident #503's family member had reported that this incident had upset and embarrassed resident #503 and also reported that the resident felt depressed about this threat.

On an identified date in 2014, RPN #001 was witnessed being physically rough with resident #501 who was cognitively impaired and forced the resident to receive specific care. It was reported that the resident was kicking and screaming as RPN #001 stripped the resident's clothing off. RPN #001 was witnessed saying to the resident "see I told you…you are going to have [care]".

It was confirmed through interviews and documentation that the written policy to promote zero tolerance of abuse and neglect of residents was not complied with when RPN #001 was abusive to residents.

C) During staff interviews, staff reported they had stopped reporting incidents involving RPN #001 to management because historically action had not been taken against the individual when previous incidents had been reported. [s. 20. (1)]

2. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained:

A) An explanation of the duty under section 24 of the Act to make mandatory reports. (Inspector #130) [s. 20. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a written complaint that had been received concerning the care of a resident or the operation of the home was immediately forwarded to the Director.

A) On an identified date in 2014, the DRC received an email from a family member outlining concerns regarding the care of an identified resident, including an allegation of staff to resident abuse. The DRC conducted an investigation into these concerns later that day and determined that the allegation of staff to resident abuse could not be confirmed. A meeting was held four days later to go over these concerns that were received in writing from the resident's POA which also contained concerns about staff putting the resident to bed early in the evening.

A review of the home's complaint log titled, Resident/Family Concern Log, indicated that this written complaint concerning the care of the resident had not been forwarded to the Director. This information was confirmed by the DRC during an interview on September 22, 2015.

The DRC confirmed on September 22, 2015, that the written complaint received concerning the care of the resident was not immediately forwarded to the Director. (Inspector #508) [s. 22. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) On an identified date in 2014, RPN #001 documented a focused progress note in resident #007's clinical record, indicating the resident exhibited a responsive behaviour towards staff, because they had requested the resident not consume three identified items at one time. However, statements from the resident and two staff confirmed the resident displayed a responsive behaviour in response to RPN #001 grabbing the item and yelling at them. This information and the actions of RPN #001 was not documented in the resident's clinical record. (Inspector #130) [s. 30. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the physical device applied in accordance with the manufacturer's instructions .

A) On an identified date in 2015, resident #012 was observed in their wheelchair with an ill fitting device applied. The DRC confirmed the device was not applied in accordance with the expectations of the home. She indicated that staff were instructed to apply the device allowing no more that two fingers to fit between the resident and the device. (Inspector #130) [s. 110. (1) 1.]

Issued on this 14th day of December, 2015

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

Ministére 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN TRACEY (130), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2015_323130_0026
Log No. / Registre no:	H-003245-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 23, 2015
Licensee / Titulaire de permis :	NIAGARA INA GRAFTON GAGE HOME OF THE UNITED CHURCH 413 Linwell Road, St. Catharines, ON, L2M-7Y2
LTC Home / Foyer de SLD :	INA GRAFTON-GAGE HOME 413 Linwell Road, St Catharines, ON, L2M-7Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PATRICK O'NEILL

To NIAGARA INA GRAFTON GAGE HOME OF THE UNITED CHURCH, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_250511_0010, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall ensure that at least one Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Grounds / Motifs :

1. Previously issued CO July 20, 2014.

The licensee did not ensure that at least one Registered Nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations. A review of the Registered Staffing Schedule for September 2015, identified a patterned absence of Registered Nurses (RN) that were filled by Registered Practical Nurses (RPN). From September 7 - 20, 2015, there were at least 29 shifts of 42 that there was no RN on duty in the home. The DRC identified they did not have an RN for these regular scheduled shifts and these shifts were replaced by an RPN. The DRC confirmed the home has been unsuccessful in recruiting Registered Nurses despite their efforts. (Inspector #130) (130)

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

Ministére 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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care for all residents, including residents #009 and #012, is provided to the resident as specified in the plan.

The home shall ensure that an auditing system is in place to ensure that specified safety devices are utilized as required and PASDs only utilized when indicated in the plan of care. Audits are to be conducted at frequencies and intervals as established by the home. The home shall provide education to registered staff on appropriate behavioural management techniques when dealing with residents with responsive behaviours.

Grounds / Motifs :

1. Previously issued as VPC on June 11, 2012 and WN on April 25, 2014.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) The plan of care for resident #009 indicated the resident required a specific safety intervention when in their wheelchair. On two identified dates in 2015, the resident sustained falls without injury, from their wheelchair. Fall incident reports, staff and the DRC confirmed the safety intervention was not in use as required in the plan of care. (Inspector #130).

B) On an identified date in 2015, resident #012 was observed in their wheelchair with an intervention in place. The resident was unable to remove the intervention when asked. The DRC observed the intervention and confirmed the resident was not suppose to have it and verified this was not a required intervention in

their written plan of care. Care was not provided as specified in the plan. (Inspector #130)

C) Resident #501 was cognitively impaired and had identified responsive behaviours.

The resident's plan of care for managing the resident's behaviour included, the intervention for staff to not express their anger or impatience verbally or with physical movements. It also directed staff not to argue or condemn the resident.

On an identified date in 2014, the resident was agitated and staff put the resident to bed to try to calm the resident down. The resident was calling out and screaming that they had to go to the bathroom. The resident was attempting to get out of bed.

A review of the clinical record indicated that RPN #001, on duty, went into the resident's room and told the resident that they would have to wait and put the resident back into the bed when the resident was trying to get up. The resident attempted to hit RPN #001 and RPN #001 caught their hand resulting in an injury.

RPN #001 then documented in the resident's clinical record that the resident demonstrated specific responsive behaviours after sustaining the injury. RPN #001 also documented that the resident was assisted back to bed after care was provided, yet they were still unhappy as they continued demonstrate responsive behaviours.

It was confirmed through review of the documentation in the resident's clinical record that the interventions were not followed and that care set out in the plan of care was not provided to the resident. (Inspector #508) [s. 6. (7)] (130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 15, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare , submit and implement a plan on how they will ensure that all residents, including residents #007 and #503 are protected from abuse by anyone and not neglected by the licensee or staff.

The plan shall include, but not be limited to the following:

1. Mandatory re-education for all staff on the the home's Abuse Prevention policy.
2. Written update to Inspector with respect to the accused Employee, including any reports made to the appropriate regulatory agency if necessary.

The plan shall be submitted to Gillian.Tracey@ontario.ca before end of business day on October 16, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) On an identified date in 2014, it was reported to the DRC that resident #503 had felt threatened by RPN #001. The resident's family member had been approached by witnesses to an incident that occurred between resident #503 and RPN #001. The resident was having difficulty sitting in an upright position independently in their wheelchair while eating. RPN #001 advised the resident in a very loud voice that if the resident couldn't sit up in the wheelchair

independently they would be transferred to the "feeding table".

The resident was upset and embarrassed as this was overheard by other residents in the dining room and the resident did not require staff assistance for eating. The resident was upset about the threat and felt "horrified" as the resident did not require that level of staff assistance. The resident was embarrassed as this occurred in a public setting and later told a family member that they were feeling depressed about the threat.

The resident was also upset about how RPN #001 was treating them when administering their medications. The resident preferred to take their medication after taking a bit of food. RPN #001 would tell the resident "You're taking the pills and you're taking them now", even if the resident had not had any food yet. During this inspection, many concerns had been brought forth to the Inspectors about how RPN #001 would yell at residents and demand that they take their pills when the RPN administered them.

During an interview with the family member, it was confirmed that the resident had felt threatened, embarrassed and upset about how RPN #001 had treated them.

After several discussions with the DRC regarding how RPN #001 was treating residents, it was confirmed by the DRC, that residents were not protected from abuse by anyone, including resident #503. (Inspector #508)

B) On an identified date in 2014, resident #007 was exhibiting symptoms and requested to be sent to the hospital for an assessment. RPN #001 on duty documented the resident's request for treatment due to specific symptoms. According to RPN #001's documentation, the resident's request was denied based on the RPN's assessment and after discussion with the resident's POA.

The clinical record confirmed that on identified date in 2015, a short time after the request for treatment was denied, tests revealed the resident required treatment intervention for their ongoing symptoms.

The DRC was interviewed by Inspector #130 and verified the resident was competent and capable of making their own decisions. The DRC confirmed the resident's request to go to hospital should have been respected.

On the specified date in 2014, resident #007 was neglected by staff. (Inspector #130).

C) During the stage one resident interviews, resident #007 reported that while they were in the dining room, their table mate had offered them an item to take back to their room, which they accepted. A staff member came over and demanded to know where the item was, so the resident advised them that they had put it in their bag to take it to their room. The resident reported a staff member held their arm to the table while a second staff searched their bag and removed it. The resident stated they were so upset by the action that they reacted in a specific manner towards staff. The resident stated they were then removed from the dining room and told by RPN #001 that residents like you go to jail for things like that. They stated the incident left them feeling scared. Three staff interviewed recalled witnessing RPN #001 yelling at the resident on the identified date in 2014. One staff reported hearing RPN #001 yelling a specific statement to the resident and witnessing RPN #001 grabbing the item away from the resident. Two others reported hearing RPN #001 yelling at the resident over the item.

On the specified date in 2014, resident #007 was not protected from abuse. (Inspector #130)

D) Resident #501 had cognitive impairment and identified responsive behaviours. It had been reported to the Inspectors that in 2014, resident #501 was demonstrating being resistive to care when staff attempted to provide specific care to the resident.

The resident's plan of care directed staff to be cognizant of not invading the resident's personal space. It also directed staff not to express their anger or impatience verbally or physically towards the resident as this will worsen responsive behaviours.

On this identified date in 2014, RPN #001 was witnessed being physically rough with resident #501 and forced the resident to receive care. It was reported that the resident was kicking and screaming as RPN #001 stripped the resident's clothing off. RPN #001 was witnessed saying to the resident "see I told you… you are going to have your bath".

It was confirmed through interviews conducted on two identified dates in 2015,

that resident #501 was not protected from abuse by RPN #001. [s. 19. (1)] (130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that the following Residents' rights are fully respected and promoted and that all staff receive mandatory re-education on the Residents' Bill of Rights.

4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs,
11.iv Every resident has the right to have his or her participation in decision-making respected.

Grounds / Motifs :

1. Previously issued VPC on June 11, 2012

1. The licensee failed to ensure that every resident had the right to have his or her participation in decision-making respected.

A) On an identified date in 2014, resident #007 was exhibiting specific symptoms and requested to be sent to the hospital for an assessment. RPN #001 on duty recorded a progress note that confirmed the resident's symptoms; however, the resident's request was denied. RPN #001 advised the resident they could wait until the following week. The resident stated they couldn't wait that long before being assessed, but the RPN #001 still denied their request to go the hospital. RPN #001 called the resident's POA and informed them of resident's "demand" to be sent to hospital via ambulance. POA agreed with the RPN that it wasn't an emergency and instructed staff not to send them

regardless of their wishes unless staff felt it necessary. RPN #001 advised the resident of the POA's instructions. The resident was not sent to hospital despite repeated requests.

The clinical record confirmed that days later, tests revealed the resident had symptoms, which required treatment.

The DRC was interviewed by Inspector #130 and verified the resident was competent and capable of making their own decisions. The DRC confirmed the resident's request to go to hospital should have been respected.

Resident #007's right to participate fully in making decisions was not respected. (Inspector #130). [s. 3. (1)]

(130)

2. The licensee failed to ensure that every resident was properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

A) According to the clinical record, resident #007 had a known diagnosis, which caused specific symptoms. On a specified date in 2014, RPN #001 observed the resident approach the public washroom. RPN #001 documented a progress note which read that the resident was reminded of the rules that they must use their own washroom. The note also stated that the resident immediately began crying and was portered to their own room. RPN #001 documented in a progress note that the resident was upset with staff at lunch today due to staff suggesting they use their own washroom instead of the public washroom this morning at breakfast. Resident agreed to do so, but was upset with staff as the incident resulted in an episode of incontinence.

The DRC was interviewed and confirmed that although the resident was encouraged to use their own washroom, the resident should not have been prohibited from using the public washroom.
Resident #007 was not cared for in a manner consistent with their needs. (Inspector #130)

B) Resident #501 had cognitive impairment and identified responsive behaviours. The physician ordered a routine anti-psychotic to manage the resident's behaviours and also ordered additional doses to be administered

when needed.

A review of resident #501's clinical record indicated that the resident demonstrated responsive behaviours on the evening and night shift on a specified date in 2014. Staff put the resident to bed to reduce the responsive behaviour which was ineffective as the resident attempted several times to climb out of the bed.

The resident was screaming that they had to go to the bathroom. RPN #001 went into the resident's room and put the resident back into bed and informed the resident who was cognitively impaired, that they would have to wait until another staff member could assist. The resident continued to scream out that they had to go to the bathroom.

RPN #001 indicated in the clinical record that during this interaction with the resident, the resident attempted to hit RPN #001 and RPN #001 caught the resident's fist and again put them back into the bed. As a result, the resident sustained an injury which was bleeding.

It was confirmed during a review of the Medication Administration Record for that date in 2014, that although the resident had demonstrated responsive behaviours for over six hours RPN #001 did not administer the resident's PRN (as needed) medication to alleviate the behaviour.

It was confirmed after review of the resident's clinical record that resident #501's rights were not fully promoted and respected when the resident was not cared for in a manner consistent with the resident's needs. (Inspector #508) [s. 3. (1) 4.]

(508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 15, 2016

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

Ministére 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

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 23rd day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : GILLIAN TRACEY

Service Area Office /
Bureau régional de services : Hamilton Service Area Office