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
Dec 28, 2018	2018_657681_0025	026108-17, 026992-18, 029568-18, 029569-18, 029570-18	Resident Quality Inspection

Licensee/Titulaire de permis

Orillia Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Leacock Care Centre
25 Museum Drive ORILLIA ON L3V 7T9

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

STEPHANIE DONI (681), JENNIFER BROWN (647), JENNIFER LAURICELLA (542), LOVIRIZA CALUZA (687), MICHELLE BERARDI (679)

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): October 15-19, 22-26, and 29-31, 2018.

The following intakes were inspected on during this RQI inspection:

- One intake related to compliance order (CO) #001 that was issued during inspection #2017_486653_0019 for s. 44 of the Ontario Regulation 79/10, specific to

the weight scales in the home.

- One intake related to CO #002 that was issued during inspection #2017_486653_0019 for s. 68 (2) (e) of the Ontario Regulation 79/10, specific to the home's weight policy.

- One intake related to CO #003 that was issued during inspection #2017_486653_0019 for s. 69 of the Ontario Regulation 79/10, specific to the assessment of residents who have experienced a significant weight change.

- One intake related to CO #004 that was issued during inspection #2017_486653_0019 for s. 90 of the Ontario Regulation 79/10, specific to the routine maintenance of the home's weight scales.

- Three intakes related to complaints submitted to the Director regarding resident care concerns.

- Four intakes related to complaints submitted to the Director regarding the staffing levels in the home.

- One intake related to a complaint submitted to the Director regarding the food services department.

- Two intakes related to allegations of resident to resident abuse.

- Three intakes related to allegations of staff to resident abuse or neglect.

- Two intakes related to the unexpected deaths of residents.

- Three intakes related to falls that resulted in injury to residents.

- One intake related to a resident who eloped from the home.

- Six intakes related to missing or unaccounted for controlled substances.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Directors of Care (Co-DOC), Culinary Manager, Environmental Manager, Staff Educators, Physician Assistant, Registered Dietitian

(RD), Life Enrichment Coordinator, Restorative Care Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, Activity Aides, Housekeeping staff, Maintenance Assistant, family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **15 WN(s)**
- **9 VPC(s)**
- **5 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. 44.	CO #001	2017_486653_0019	681
O.Reg 79/10 s. 68. (2)	CO #002	2017_486653_0019	681
O.Reg 79/10 s. 69.	CO #003	2017_486653_0019	681
O.Reg 79/10 s. 90. (1)	CO #004	2017_486653_0019	681

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

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 has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A Critical Incident System (CIS) report was submitted to the Director for an incident that caused injury to a resident, for which the resident was taken to hospital, and that resulted in a significant change to the resident's health status. The CIS report identified that a PSW improperly used a specified device to transfer resident #012, which resulted in the resident sustaining an injury.

On a specified date, Inspector #679 observed resident #012 in the dining room with a specified mobility aid.

Inspector #679 reviewed the resident's care plan, which indicated that the resident used another mobility aid, but the care plan did not identify the use of the mobility aid that the resident had been observed with by the Inspector.

In an interview with PSW #147, they identified that resident #012 used a specified mobility aid. Together, Inspector #679 and PSW #147 reviewed the electronic Kardex. PSW #147 identified that the Kardex did not outline the use of the specified mobility aid, but did identify that another mobility aid was used. PSW #147 identified that they were unsure what the other specified mobility aid was.

In separate interviews with Inspector #679, PSW #126, PSW #148, RPN #117 and RPN #148 all identified that they did not know what the other specified mobility aid was.

A review of the policy entitled "Resident Rights, Care and Services- Plan of Care- Plan of Care" last revised March 13, 2018, identified that there should be a written plan of care for each resident that sets out the planned care for the resident, the goals the care was intended to achieve and clear directions to staff who provided direct care to the resident.

Together, Inspector #679 and the DOC reviewed the resident's care plan related to the use of mobility aids. The DOC confirmed that the care plan did not provide clear direction to staff if staff identified they did not know what the other identified mobility aid was. [s. 6. (1) (c)]

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

a) During an interview with Inspector #542, resident #023's substitute decision-maker (SDM) indicated that the home was not ensuring that the resident used a specified intervention for falls prevention and that they were not following the resident's care plan. Resident #023's family member proceeded to show Inspector #542 the resident's specified falls prevention intervention, which was not being utilized.

Inspector #542 completed a review of resident #023's current care plan, which identified the specified falls prevention intervention.

The Inspector reviewed a progress note in the resident's health care record, which identified that resident #023's SDM had brought forth concerns to the home regarding

resident #023 not using the specified falls prevention intervention.

An interview was conducted with the home's Restorative Care Coordinator, who was also the lead for the Falls Prevention Committee. They indicated that resident #023 did not utilize the specified falls prevention intervention.

b) During the same interview with Inspector #542, resident #023's SDM also indicated that they did not believe that resident #023 was receiving oral care nor were they receiving a specified continence intervention.

A review of resident #023's health care record was completed by Inspector #542. The current care plan identified that a specified continence intervention was to be implemented. It was documented that staff were to provide oral hygiene every morning and at night.

Inspector #542 interviewed PSW #108 who indicated that resident #023 did not receive a specified continence intervention and that the resident refused assistance with oral hygiene.

An interview was conducted with PSW #152, who stated that they no longer provided the resident with oral care because resident #023 would not allow it. They further stated that resident #023 did not require a specified continence intervention. [s. 6. (7)]

3. The home submitted a CIS report to the Director related to the unexpected death of resident #014. The CIS report indicated that resident #014 fell on a specified date and that a specific assessment was completed with no abnormal results. The CIS report further indicated that resident #014 was found two days later with vital signs absent.

Inspector #647 reviewed a home policy related to Resident Rights, Care, and Services, which indicated that a specific assessment was to be completed at specified intervals following certain incidents or injuries.

A review of the documentation completed after the resident's fall indicated that the scheduled assessment was not completed on four separate occasions.

During interviews with RN #118 and RPN #117, they indicated that the specified assessment was required in specific circumstances. RPN #117 indicated that they were working at the time of resident #014's fall and had initiated the specified assessment.

During an interview with Co-DOC #122, they acknowledged that it was documented on four occasions that the specified assessment had not been completed for resident #014. Co-DOC #122 indicated to the Inspector that the specified assessment was required to be completed during all the assigned times. Co-DOC #122 confirmed that, as a result of the specified assessment not being completed, the plan of care for resident #014 was not followed. [s. 6. (7)]

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

The home submitted a CIS report to the Director related to an unexpected death of resident #014. Refer to WN #1, Part Three for details.

Inspector #647 reviewed documentation from a specified assessment completed after resident #014's fall, which indicated that on three separate occasions staff had not documented the specified assessment as scheduled.

During an interview with Inspector #647, Co-DOC #122 reviewed the documentation for resident #014 and acknowledged that there were gaps in the documentation for the specified assessment. Co-DOC #122 further indicated that the staff should have been documenting at the scheduled intervals for the specified assessment. [s. 6. (9)]

5. Two CIS reports were submitted to the Director outlining allegations of resident to resident sexual abuse. The first CIS report was submitted for an incident that occurred where resident #006 was directing a sexual behaviour towards resident #007. The second CIS report was submitted for a similar incident that occurred approximately one month later.

Inspector #542 completed a review of resident #006's health care record. The progress notes included documentation which indicated that the home had instituted a specified intervention for resident #006.

Inspector #542 reviewed documentation of the specified intervention for a specific 45 day time period. It was observed by the Inspector that on 22 of the 45 days, the documentation for the specified intervention was incomplete.

Inspector #542 interviewed Co-DOC #102 and Co-DOC #122 regarding the

documentation for the specified intervention. Co-DOC #102 and Co-DOC #122 both verified that the documentation was incomplete. [s. 6. (9)]

6. A CIS report was submitted to the Director about an incident that occurred involving resident #015, which resulted in resident #015 sustaining an injury.

Inspector #647 reviewed resident #015's health care record, which indicated that they had been admitted to the home on a specified date and had immediately began to exhibit specific behaviours. The health care record further indicated that resident #015 was transferred to another home area to reduce their safety risk and a specified intervention was also initiated.

Inspector #647 reviewed the documentation for the specified intervention for a specific six week time period. The Inspector was unable to identify consistent documentation for the specified intervention. The records indicated that the documentation was incomplete on 12 separate dates within the six week time period.

During an interview with Co-DOC #122, a review of the above indicated documentation for resident #015 was conducted. Co-DOC #122 acknowledged the gaps in documentation for the required intervention and further indicated that the staff should have been documenting at the required intervals. [s. 6. (9) 1.]

7. A CIS report was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health status. The CIS report identified that resident #013 fell and sustained an injury.

Inspector #679 reviewed resident #013's health record and identified documentation for a specified intervention. It was identified that on five occasions, the documentation for the intervention was blank. In addition to the blank documentation, there were six other occasions in which the document identified that the specified intervention had not been completed.

In an interview with RPN #117, they identified that the specified intervention was completed in specific circumstances. Together, Inspector #679 and RPN #117 reviewed the documentation for this resident and RPN #117 identified that it was the expectation that the documentation be completed.

In an interview with Co-DOC #102, they identified that the specified intervention would be completed in specific circumstances. Together, Inspector #679 and Co-DOC #102 reviewed the documentation for resident #013. Co-DOC #102 confirmed that it was the expectation that the documentation was completed. [s. 6. (9) 1.]

8. A complaint was submitted to the Director outlining concerns regarding the falls that resident #005 had sustained. The complaint identified that resident #005 was supposed to receive a specified intervention, but that staff did not complete this intervention due to short staffing.

a) Inspector #679 reviewed resident #005's health care record and identified that the specified intervention was to be completed and there were specific instructions for staff who completed this intervention. Inspector #679 identified that documentation for this specified intervention was not completed on six occasions.

In an interview with PSW #157, they identified that if a resident was receiving the specified intervention, it would be documented in the resident's health care record. Together, Inspector #679 and PSW #157 reviewed the documentation and PSW #157 confirmed that it was the expectation that this documentation be completed.

In an interview with RPN #148, they identified that if a resident was receiving the specified intervention, it would be documented in the resident's health care record. Together, Inspector #679 and RPN #148 reviewed the documentation and RPN #148 confirmed that it was the expectation that the documentation was completed on each shift.

b) Inspector #679 reviewed resident #005's health care and identified four forms for the documentation of another specified intervention. The Inspector identified that on a total of 16 occasions, there was blank documentation within the four forms.

In an interview with RPN #117, they identified that a specified intervention was completed in specific circumstances. Together, Inspector #679 and RPN #117 reviewed the forms for this resident. RPN #117 identified that it was the expectation that the documentation be completed.

In an interview with Co-DOC #102, they identified that the specific intervention was completed in specific circumstances. Together, Inspector #679 and Co-DOC #102 reviewed the documentation. Co-DOC #102 confirmed that it was the expectation that

the documentation be completed. [s. 6. (9) 1.]

9. The licensee has failed to ensure that the resident was reassessed and the plan of care was 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 was no longer necessary.

A CIS report was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health status. The CIS report identified that resident #011 fell and sustained an injury.

Inspector #679 reviewed the progress notes in resident #011's health care record, which identified that the resident had a previous fall on a specified date. The progress note, written by the Restorative Care Coordinator, identified that the staff would trial the use of a specified intervention to prevent further falls.

The Inspector reviewed the resident's care plan and identified that the use of the specified intervention was not documented in the care plan.

A review of the policy entitled "Resident Rights, Care and Services- Plan of Care- Plan of Care" last updated March 13, 2018, identified that the plan of care shall be reviewed and revised when the resident's care needs changed, the care set out in the plan was no longer necessary, or the care set out in the plan had not been effective.

In an interview with Inspector #679, RPN #111 identified that staff would reference a resident's care plan to determine which fall prevention interventions were in place. Inspector #679 reviewed the progress note, which indicated that staff would trial the use of the specified intervention to prevent further falls. RPN #111 identified that this intervention should have been listed in the care plan. Together, Inspector #679 and RPN #111 reviewed the electronic care plan, and identified that the use of the specified intervention was not outlined in the care plan.

In an interview with the DOC, they identified that staff would reference a resident's care plan to determine fall prevention interventions. Together, Inspector #679 and the DOC reviewed the progress notes and care plan in the resident's health care record. The DOC identified that the use of the specified intervention was not included in the care plan and stated that, if it was something being trialed, then it should be included in the care plan. [s. 6. (10) (b)]

10. A CIS report was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health status. The CIS report identified that a PSW improperly used a specified device to transfer resident #012, which resulted in the resident sustaining an injury.

Inspector #679 observed resident #012 with a specified falls prevention intervention in place on several occasions.

In an interview with PSW #127, they identified that resident #012 had a specified falls prevention intervention. PSW #127 identified that these interventions would be identified in the resident's care plan.

Inspector #679 reviewed resident #012's current care plan, which did not identify the use of the specified falls prevention intervention.

Inspector #679 reviewed an electronic progress note, which indicated that resident #012 was provided with the specified falls prevention intervention on a specific date.

In an interview with RPN #148, they identified that resident #012 had a specified intervention in place to prevent falls and that falls prevention interventions would be outlined in the care plan. Together, Inspector #679 and RPN #148 reviewed the resident's current care plan and did not identify the use of the specified intervention.

In an interview with the Restorative Care Coordinator, they identified that this resident had a specified intervention in place to prevent falls and that falls prevention interventions should be listed in the care plan. The Inspector and Restorative Care Coordinator reviewed the electronic care plan and identified that the use of the specified intervention was not outlined in the care plan.

Together, Inspector #679 and the DOC reviewed the care plan and the DOC identified that the falls prevention intervention should have been inputted into the care plan when it was initiated. [s. 6. (10) (b)]

11. A CIS report was submitted to the Director for an incident that caused injury to a resident, for which the resident was taken to hospital and that resulted in a significant change in the resident's health status. The CIS report identified that resident #013 fell

and sustained an injury.

Inspector #679 reviewed the resident's health care record and identified that resident #013 sustained a specified number of falls prior to the fall with injury. The Inspector identified a progress note, which indicated that the Restorative Care Coordinator had suggested that staff implement a specified intervention to decrease the risk of falls. The Inspector also identified a second progress note, which indicated that the Restorative Care Coordinator provided resident #013 another specified falls prevention intervention.

Inspector #679 reviewed the care plan and identified that neither of the interventions were listed in the resident's care plan.

Together, Inspector #679 and the Restorative Care Coordinator reviewed the resident's care plan and progress notes. The Restorative Care Coordinator identified that they did not see the interventions listed in the care plan.

Together, Inspector #679 and Co-DOC #102 reviewed resident #013's care plan and did not observe the interventions listed in the care plan. Co-DOC #102 stated that the interventions should have been included in the resident's care plan. [s. 6. (10) (b)]

12. A complaint was submitted to the Director outlining concerns about the falls that resident #005 sustained.

In an interview with the RPN #117, they identified that resident #005 used a specified intervention to prevent falls.

Inspector #679 reviewed the care plan for this resident and identified that the use of the intervention was not included in the resident's care plan.

In an interview with the Restorative Care Coordinator, they identified that resident #005 had a specified intervention to prevent falls. Together, Inspector #679 and the Restorative Care Coordinator reviewed resident #005's care plan. The Restorative Care Coordinator identified that the use of the specified intervention was not in this resident's care plan, and that this intervention should have been listed in the care plan.

In an interview with Co-DOC #102 they identified that fall prevention interventions would be listed in the care plan. Together, Co-DOC #102 and Inspector #679 reviewed the electronic care plan. Co-DOC #102 confirmed that they did not see the use of the

specified falls prevention intervention outlined in resident #005's care plan. [s. 6. (10) (b)]

13. During an interview with Inspector #542, resident #023's SDM indicated that the home was not following the resident's care plan.

Inspector #542 completed a review of resident #023's current care plan and identified that a specified falls prevention intervention was listed in the care plan.

An interview was conducted with the home's Restorative Care Coordinator, who was also the lead for the Falls Prevention Committee. They indicated that resident #023 no longer used the specified intervention because it was posing a safety risk to the resident. The Restorative Care Coordinator further confirmed that the care plan had not been revised. [s. 6. (10) (b)]

14. The licensee has 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 care set out in the plan of care has not been effective.

A complaint was submitted to the Director outlining concerns regarding the number of falls that resident #005 had sustained.

Inspector #679 reviewed resident #005's health care record and identified eight progress notes that had been written regarding resident #005's falls. Six of the eight progress notes identified that the falls prevention interventions had not been reassessed or revised.

A review of the home's policy titled "Resident Rights, Care and Services- Plan of Care- Plan of Care" last revised on March 13, 2018, identified that the plan of care shall be reviewed and revised when the resident's care needs change; the care set out in the plan was no longer necessary; or the care set out in the plan had not been effective. The policy further identified that when the care plan was being revised because the care set out in the plan had not been effective, different approaches were to be considered in the revision of the care plan.

A review of the policy entitled "Resident Rights, Care and Services- Required Programs- Falls Prevention and Management- Program" last revised October 22, 2018, identified that staff were to ensure that when a resident had sustained a fall, a post fall assessment progress note would be completed, and that the note would include additional

interventions to prevent further falls or injury.

In an interview with RN #153, they identified that falls prevention interventions were to be reassessed after every fall and that resident #005's interventions should have been reassessed.

In an interview with Co-DOC #102 they identified that falls prevention interventions would be reassessed with every fall to see if they were still effective. Co-DOC #102 identified that the Restorative Care Coordinator would look at the interventions after the fall to determine if the interventions were effective. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001, 005 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 care is provided to the resident as specified in the plan of care and to ensure that the plan of care is reviewed and revised when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: 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. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Two CIS reports were submitted to the Director outlining allegations of resident to resident sexual abuse. Please refer to WN #1, Part Five for details.

Inspector #542 reviewed resident #006's health care record. It was documented in the care plan and in the progress notes that the home had implemented a specified intervention for resident #006 after the first incident occurred. Inspector #542 was unable to locate any further documentation to indicate that the home had discontinued the specified intervention for resident #006.

During an interview with the Administrator, they indicated that resident #006 was to have the specified intervention implemented on the date the second incident occurred. However, the home did not have a full complement of staff working on that date and staff members had to be re-assigned. As a result, the specified intervention for resident #006 was not implemented on the date the second incident occurred.

2. Four complaints were submitted to the Director regarding the staffing levels in the home. During the inspection, residents #021, #045, #046, and #047 also reported that they did not believe that the home had sufficient staff to provide them the care and assistance that they required.

a) Inspector #542 reviewed the "bathing/toileting" audit tool from a specified home area for a particular date. It was documented that residents #016, #043 and #044 received a bed bath.

The Inspector reviewed the progress notes for residents #016, #043 and #044. For all three residents it was documented "scheduled bath day, bed bath offered."

A review of resident #016's current electronic care plan was completed. It was documented that the resident preferred a shower. Resident #043's current care plan revealed that they were to be offered a tub bath or shower and to let the resident choose. Resident #044's current care plan indicated that they preferred a shower.

Inspector #647 interviewed PSW #109, who indicated that the specified home area did not have a full complement of PSW staff on the particular date. PSW #109 further stated that two of the scheduled baths/showers (for residents #016 and #043) were not completed as a result of short staffing.

b) Inspector #679 reviewed the progress notes in resident #012's health care record and identified that on another specified date, RPN #148 documented that staff were unable to give resident #012 their bath due to short staffing.

The Inspector identified that that there was no documentation regarding resident #012's bath in the resident's health care record for the specified date. The next documented bath was three days later.

Inspector #679 reviewed the documentation with RPN #148. RPN #148 identified that when a resident's bath was missed, staff would "make a note for the day staff to do [the resident's] bath on the next shift".

3. A CIS report was submitted to the Director for an incident that caused injury to a resident for which the resident was taken to hospital and that resulted in a significant change to the resident's health status. Please refer to WN #4, Part One for additional details.

Inspector #679 reviewed the home's internal investigation related to the incident, which included documentation from an interview with PSW #140. The documentation indicated that PSW #140 identified that the home was short staffed on the date of the incident, that PSW #140 was not familiar with the residents, and that there was not a second staff member assisting PSW #140.

In an interview with PSW #137, they identified that they were working when resident #012's fall and injury occurred. PSW #137 identified that a specified device had been used improperly to transfer resident #012.

In an interview with the DOC, they identified that staff were to follow the home's policy when transferring residents using the specified device.

4. Resident #023's family member indicated that resident #023 required a specific intervention for all transfers and that the resident was frequently transferred incorrectly. Please refer to WN #4, Part Two for additional details.

Inspector #542 interviewed PSW #127, who indicated that they often transferred resident #023 incorrectly due to short staffing.

Inspector #542 interviewed the Restorative Care Coordinator, who was responsible for

assessing residents for their transferring ability, along with the Physiotherapists. They confirmed that resident #023 was to have a specified intervention for all transfers. [s. 8. (1) (b)]

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. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies had been developed and implemented to respond to the resident that demonstrated responsive behaviours.

A CIS report was submitted to the Director about an incident that had occurred involving resident #015. Please refer to WN #1, Part Six for further details.

Inspector #647 reviewed resident #015's health care records, which indicated that resident #015 began to exhibit specified behaviours immediately following their admission to the home.

A review of the plan of care for resident #015 indicated that it was initiated when the resident was admitted to the home. The Inspector identified that the initial plan of care included the resident's specified behaviours, as well as, three initial interventions.

A review of the progress notes indicated that resident #015 continued to exhibit the specified behaviours on eight separate occasions prior to the incident for which the CIS report was submitted.

A further review of the plan of care for resident #015 indicated that there had not been any further strategies developed or implemented to respond to the resident's specified behaviours.

During a meeting with the Administrator, they acknowledged that specified behaviours were identified when resident #015 was admitted to the home. Documents reviewed included a new admission email that was sent to the management team which identified that resident #015 was known to exhibit specified behaviours, as well as a multidisciplinary care conference note, which indicated resident #015 was a particular safety risk. The Administrator further acknowledged that there had been no new strategies developed or implemented to address the resident's specified behaviours since the resident was admitted to the home. [s. 53. (4) (b)]

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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

A CIS report was submitted to the Director for an incident that caused injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health status. The CIS report identified that a PSW improperly used a device to transfer resident #012, which resulted in the resident sustaining a fall that resulted in injury.

Inspector #679 reviewed the home's internal investigation related to the incident and identified an account of the incident completed by DOC #138. The statement identified that PSW #140 improperly used a device to transfer resident #012. The home's internal investigation file also contained documentation, which identified that the home was short staffed on the date of the incident, that PSW #140 was not familiar with residents, and that there was not a second staff member assisting PSW #140 at the time of the incident.

In an interview with PSW #137, they identified that they were working when resident #012's fall occurred. PSW #137 identified that they had heard yelling, and found resident #012 on the floor. PSW #137 identified that the device used to transfer resident #012 had not been used correctly.

In an interview with the DOC, they identified that the staff member had not transferred resident #012 as per the home's policy. [s. 36.]

2. During an interview with Inspector #542, resident #023's SDM stated that the staff were not transferring resident #023 appropriately. Resident #023's SDM indicated that the resident required a specified intervention for all transfers and that the resident was frequently transferred improperly. Furthermore, during the interview, Inspector #542 observed a PSW improperly transfer resident #023.

A review of resident #023's health care record was completed by Inspector #542. The current care plan identified that resident #023 required a specified intervention for all transfers.

On a second occasion, Inspector #542 observed PSW #142 improperly transfer resident #023. On a third occasion, the Inspector observed PSW #143 improperly transfer resident #023.

During an interview with PSW #142, they indicated that they typically used a particular method to transfer resident #023 because it was easier and the resident became agitated when this method was not used.

During an interview with PSW #143, they indicated that they were unaware of what resident #023's care plan indicated regarding transfer interventions.

During an interview with PSW #127, they indicated that they often transferred resident #023 using a particular method due to short staffing. They further indicated that it was easier to transfer resident #023 using this method.

Inspector #542 interviewed the Restorative Care Lead, who was responsible for assessing residents for their transferring ability, along with the Physiotherapists. They confirmed that resident #023 was assessed and was to be transferred with a specified intervention. [s. 36.]

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. 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 where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with Ontario Regulation 79/10, s. 49. (1), the licensee was to ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Specifically, staff did not comply with the licensee's policy regarding "Resident Rights, Care and Services- Required Programs- Falls Prevention and Management- Program" last revised October 22, 2018, which was part of the licensee's Fall Prevention and Management Program.

A complaint was submitted to the Director outlining concerns regarding the falls that resident #005 sustained.

a) Inspector #679 reviewed the progress notes in the resident's health care record and identified that there was only one “fall follow up note” completed after the resident fell on three specified dates. The Inspector also identified that there were only two “fall follow up notes” completed when the resident fell on another specified date.

A review of the policy entitled “Resident Rights, Care and Services- Required Programs- Falls Prevention and Management Program” last revised October 22, 2018, identified that staff will ensure that a fall follow up progress note was completed for at least three

shifts following the incident.

In an interview with RN #153, they identified that the post fall follow up notes were to be completed for 24 hours post fall, and that there should be three follow up notes. Together, Inspector #679 and RN #153 reviewed the progress notes for the post fall assessments. RN #153 confirmed that there was only one "fall follow up note" completed after the resident fell on three specified dates and that there were only two “fall follow up notes” completed when the resident fell on another specified date.

In an interview with Co-DOC #102, they identified that the post fall follow up notes would be completed on every shift for three shifts. Together, Inspector #679 and Co-DOC #102 reviewed the progress notes in the resident's health care record. Co-DOC #102 confirmed that there was one “fall follow up note” completed after the resident fell on three specified dates and two "fall follow up notes" completed on another specified date. Co-DOC #102 confirmed that the expectation was that staff completed three fall follow up notes post fall.

b) In an interview with the Restorative Care Coordinator they identified that the restorative care/physiotherapy referrals were sent to them after each fall.

Inspector #679 reviewed the electronic restorative care/physiotherapy referral assessments and could not identify that a referral was sent to restorative care/physiotherapy after the resident's falls on two specified dates.

Together, Inspector #679 and the Restorative Care Coordinator reviewed the electronic referrals. The Restorative Care Coordinator identified that they did not receive a referral for the falls that occurred on the two specified dates.

A review of the policy entitled “Resident Rights, Care and Services - Required Programs-Falls Prevention and Management Program” last revised October 22, 2018, identified that staff were to ensure that the resident was referred to physiotherapy post fall.

In an interview with Co-DOC #102, they identified that restorative care/physiotherapy referrals were to be completed after each fall. Together, Inspector #679 and Co-DOC #102 reviewed the electronic referrals. Co-DOC #102 confirmed that there was no referral completed for resident #005’s falls that occurred on the two specified dates. [s. 8. (1) (a),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 to ensure that the home's Fall Prevention and Management Program 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 has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Ontario Regulation 79/10 defines physical abuse as the use of physical force by anyone other than a resident that caused physical injury or pain.

During the inspection, resident #038 reported to Inspector #687 that a staff member was rough with them while providing personal care and that this had not been reported to the home. The Inspector subsequently notified the home of the allegation that was reported to them and a CIS report was submitted to the Director. The CIS report indicated that PSW #154 was rough while providing care to resident #038.

During an interview with resident #038, they stated that PSW #154 was rough while providing personal care and that the PSW spoke to them in an inappropriate and disrespectful manner.

The Inspector reviewed the home's policy titled "Resident Rights, Care and Services – Abuse- Zero Tolerance Policy for Resident Abuse and Neglect" last revised June 2,

2017, which indicated that the home had a zero tolerance policy for resident abuse and neglect. The policy further indicated that "zero tolerance" means that the licensee shall uphold the right of residents to be treated with dignity and respect within the long-term care facility, and to live free from abuse and neglect.

In an interview with the Administrator, they stated that the home initiated their investigation shortly after Inspector #687 informed them of the alleged physical abuse reported by resident #038. The Administrator informed the Inspector that PSW #154 declined to comply with the home's internal investigation. As a result of this, and based on their internal investigation, the Administrator stated that there was an element of physical abuse on the part of PSW #154. [s. 20. (1)]

2. Ontario Regulation 79/10 defines verbal abuse as 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

During the inspection, resident #034's family member reported to Inspector #681 that, on a particular date, they observed that resident #041 was visibly upset. Resident #034's family member then heard RPN #130 speak to resident #041 in an inappropriate manner.

During an interview with RPN #130, they stated that they did not recall saying the statement that they were accused of saying.

Inspector #681 reviewed a copy of the home's investigation file, which included a letter of discipline addressed to RPN #130. The letter of discipline indicated that the allegation of verbal/emotional abuse was founded.

During an interview with the DOC, they stated that, as a result of the home's investigation, RPN #130 received disciplinary action.

During an interview with the Administrator, they stated that RPN #130 received disciplinary action related to the incident. [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 to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Inspector #542 reviewed the "bathing/toileting" audit tool from a specified home area for a particular date. It was documented that residents #016, #043 and #044 received a bed bath. Inspector #542 reviewed the progress notes in resident #016's, #043's, and #044's health care record. It was documented for all three residents, "scheduled bath day, bed bath offered." According to the bathing assignment from the home area, all three residents were scheduled to have their bath/shower on the particular date.

A review of resident #016's current electronic care plan was completed. It was documented that the resident preferred a shower. Resident #043's current care plan revealed that they were to be offered a tub bath or shower and to let the resident choose. Resident #044's current care plan indicated that they preferred a shower.

Inspector #647 interviewed PSW #109, who verified that the home area did not have a full complement of PSW staff on the particular date. PSW #109 further indicated that two of the scheduled bath/showers were not completed (resident #016 and #043), as a result of short staffing.

2. Inspector #679 reviewed resident #012's electronic progress notes and identified that on another particular date, RPN #148 documented that staff were unable to give resident #012 their bath due to staffing.

The Inspector identified that that there was no documentation regarding resident #012's bath in the resident's health care record for the specified date. The next documented bath was three days later.

Inspector #679 reviewed the electronic progress note with RPN #148. RPN #148 identified that when a resident's bath was missed staff would "make a note for the day staff to do [the resident's] bath on the next shift". [s. 33. (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 to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the equipment, supplies, devices and assistive aids for fall prevention and management were readily available at the home.

Inspector #542 interviewed RPN #120 to discuss falls prevention interventions. RPN #120 indicated that, during the evening, they do not have access to falls prevention equipment. RPN #120 further indicated that they would have to submit a referral and it would be looked at the next day.

Inspector #679 interviewed RN #153 regarding falls prevention interventions and equipment. RN #153 indicated that they sent a referral to the Restorative Care Coordinator in order to obtain a specified falls prevention device for a specific resident, however the resident did not have the specified device as of yet. RN #153 indicated that they do not have access to falls prevention equipment when working nights.

Inspector #542 and #679 interviewed the lead for the Falls Prevention Committee, who was also the home's Restorative Care Coordinator. They verified that, in the evening and during the night, staff would not have access to the supplies or equipment for falls prevention and that they would have to wait unit the next day and then they would be provided what was required. [s. 49. (3)]

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 equipment, supplies, devices and assistive aids for fall prevention and management are readily available in the home, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent received an assessment that included the identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for the assessment of incontinence.

Resident #019 was identified as experiencing a continence decline during their admission to 90 day Minimum Data Set (MDS) assessment.

Inspector #679 reviewed resident #019's admission and 90 day MDS assessments, which identified that the resident had experienced a decline in their continence status over the past three months since their admission to the home.

Inspector #679 reviewed the resident's health care record and identified one "Assessment of Continence", which was completed when the resident was admitted to the home.

Inspector #679 reviewed the policy entitled "Resident Rights, Care and Services- Required Programs- Continence Care and Bowel Management Program" last revised February 28, 2018, which identified that referrals and additional assessment for

continence were to be completed with any decline in bowel and/or bladder continence indicated in the completed RAI-MDS.

Together, Inspector #679 and RPN #107 reviewed the electronic assessments for resident #019. RPN #107 confirmed that there was one assessment of continence completed for resident #019, and identified that these assessments were to be completed on admission and with any significant change.

In an interview with the DOC, they identified that continence assessments were completed upon admission and with any significant change in continence. Together, Inspector #679 and the DOC reviewed the continence assessments and MDS assessments for resident #019. The DOC identified that a continence assessment should have been completed. [s. 51. (2) (a)]

2. Resident #020 was identified as being incontinent through their most recent MDS assessment.

Inspector #679 reviewed the quarterly MDS assessment completed on a specified date, which identified that the resident was incontinent.

Inspector #679 reviewed the electronic assessments tab and identified one "Assessment of Continence", which identified that the resident was continent.

Together, Inspector #679 and RPN #107 reviewed the electronic assessments for resident #020. RPN #107 confirmed that there was one assessment of continence completed for resident #020, and identified that these assessments were to be completed at admission and with any significant change. RPN #107 identified that there had been a change in resident #020's continence status and that they would be opening a new continence assessment.

In an interview with the DOC, they identified that continence assessments were completed upon admission and with any significant change in continence. Together, Inspector #679 and the DOC reviewed the continence assessments and MDS assessments for resident #020. The DOC identified that another continence assessment should have been completed. [s. 51. (2) (a)]

3. Inspector #542 was informed by resident #023's family member that the resident was not receiving a specified intervention related to continence.

Inspector #542 reviewed a continence assessment that was completed when resident #023 was admitted to the home. It was documented on the assessment that resident #023 was continent. A review of the health care record for resident #023 revealed that no other continence care assessments were completed.

Inspector #542 reviewed the last two completed quarterly MDS assessments. Both assessments indicated that resident #023 was incontinent and that their condition had deteriorated.

Inspector #542 interviewed PSW #108 who indicated that resident #023 was incontinent and that they received a specified intervention related to continence.

An interview was conducted with PSW #152, who stated resident #023 was incontinent.

Inspector #542 interviewed the Co-DOC #103 regarding continence care assessments. They indicated that when a resident's continence care needs change, another assessment was to be completed and the care plan was to be updated. [s. 51. (2) (a)]

4. The licensee has failed to ensure that a resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on their assessment and that the plan was implemented.

Resident #019 was identified as experiencing a continence decline during their admission to 90 day MDS assessment.

Inspector #679 reviewed the resident's electronic care plan, which identified that a the resident had a specified continence intervention in place.

Inspector #679 reviewed the resident's electronic admission "Assessment of Continence" which identified that the resident had a different specified intervention related to continence.

In an interview with PSW #110, they identified that resident #019 required the continence intervention that was identified in the resident's "Assessment of Continence". PSW #110 identified that resident #019 did not utilize the continence intervention that was identified in their electronic care plan. PSW #110 identified that they would reference a resident's Kardex for information about their continence status.

A review of the policy entitled "Resident Rights, Care and Services- Required Programs- Continence Care and Bowel Management" last revised February 28, 2018, identified that staff were to ensure that each resident who was incontinent was to have an individualized plan, as part of their care to promote and manage bowel and bladder continence based on their assessment.

In an interview with RPN #117, they identified that resident #019 was incontinent. RPN #117 identified that resident #019 did not use the continence intervention identified in their care plan. RPN #117 identified that care plans were to be updated if there was a change in a resident's continence status.

In an interview with the DOC, they identified that care plans were initiated upon admission and were updated whenever there was a change. Together, Inspector #679 and the DOC reviewed resident #019's care plan. The DOC identified that it appeared the care plan was not personalized, and that the use of the specified continence intervention should have been removed from the care plan. [s. 51. (2) (b)]

5. A complaint was submitted to the Director related to continence care for resident #034.

The Inspector reviewed the resident's Quarterly Continence Care Assessment, which identified that resident #034 utilized a specific continence intervention.

Inspector #687 reviewed resident #034's care plan, which indicated that the resident was incontinent and required a different continence intervention.

In an interview with PSW #145, they stated that resident #034 did not require the continence intervention that was identified in their care plan, but that they utilized the continence intervention that was identified in the resident's Quarterly Continence Care Assessment.

In an interview with RPN #148, they verified that resident #034 did not require the continence intervention identified in their care plan, and that the resident had never required this intervention. The RPN stated that the resident utilized the continence intervention that was identified in their Quarterly Continence Care Assessment. RPN #148 acknowledged that the resident's care plan was not updated to reflect the current status of the resident.

In an interview with the Continence Care Lead, they stated that the resident's care plan was supposed to be updated by the registered staff two weeks after the MDS assessment. The Continence Care Lead recognized that resident #034's care plan was not updated to reflect the resident's current continence care interventions.

b) On a specified date, Inspector #687 observed resident #034 in the dining room and other common areas of the home for a specific one hour and 20 minute time period. The Inspector did not observe any staff member provide continence care to resident #034.

In a subsequent observation conducted by Inspector #687, resident #034 was observed for a specific two hour time period and the Inspector did not observe any staff member provide continence care to the resident.

The Inspector reviewed resident #034's care plan, which indicated that staff were to provide the resident with continence care at specified times.

In an interview with PSW #156, they stated that the staff would provide the resident with continence care at specified times throughout the day.

In an interview with PSW #147, they verified that resident #034 was not provided with continence care over a specified two and a half hour time period on a particular date.

In an interview with the Continence Care Lead, they stated that, if the resident's care plan identified that the resident was supposed to be provided with continence care at specific times, then it was the expectation that staff members provided the care as per the resident's care plan. [s. 51. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident who is incontinent receives an assessment and that there is an individualized plan to promote and manage bowel and bladder continence based on the assessment, and that the plan is implemented, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 77. Food service workers, minimums

Specifically failed to comply with the following:

s. 77. (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,
(a) the preparation of resident meals and snacks; O. Reg. 79/10, s. 77 (1).
(b) the distribution and service of resident meals; O. Reg. 79/10, s. 77 (1).
(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and O. Reg. 79/10, s. 77 (1).
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 79/10, s. 77 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there were sufficient food service workers for the home to meet the minimum staffing hours outlined in the Ontario Regulation 79/10.

The Ontario Regulation 79/10 defines food service worker as a member of staff in a long-term care home who is routinely involved in the storage, preparation, cooking, delivery or serving of food, the cleaning of kitchen equipment and utensils or the maintaining of the kitchen and serveries in a clean and sanitary condition, but does not include the nutrition manager for the home.

Section 77 (2) of the Ontario Regulation 79/10, identifies that a home with a licensed bed capacity of 145 beds would require 456.7 food service worker hours per week for:
a) the preparation of resident meals and snacks;
b) the distribution and service of resident meals;
c) the receiving, storing and managing of the inventory of resident food and food service supplies; and
d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service.

A complaint was submitted to the Director related to the training and education of food service workers in home. During the inspection, residents #047 and #048 also reported that there were not always enough servers during meals and that they sometimes had to

wait a long time to be served their meal.

On a particular date, Inspector #681 observed that residents in one of the dining rooms were served their supper meal on paper plates. During an interview with Dietary Aide #163, they indicated that the supper meal was served on paper plates because the home was short food service staff.

On a subsequent date, Inspector #542 observed that residents in another dining room were served their dinner and dessert on paper plates.

Together with the Culinary Manager, Inspector #681 reviewed the number of food service hours worked for a three week time period. During the first week reviewed, 376 food service hours were worked; during the second week, 405.5 food service hours were worked; and during the third week, 336.75 food service hours were worked.

During an interview with the Culinary Manager, they stated that they were aware that food service staffing was a concern. The Culinary Manager acknowledged that the home used paper plates for supper on a specified date, because there was only one food service staff scheduled to work after 1730 hours. The Culinary Manager verified that the home was not meeting the minimum number of required food service hours. [s. 77. (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 there are sufficient food service workers to meet the minimum staffing hours outlined in the Ontario Regulation 79/10, to be implemented voluntarily.

WN #11: 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 controlled substances were stored in a separate, double-locked stationary cupboard in a locked area or stored in a separate locked area within the locked medication cart.

Inspector #687 conducted an interview with RN #105 in relation to the storage of controlled substances in the home. The RN stated that controlled substances were kept in a locked box inside a locked medication cart, which was kept in a locked location in the home. The RN further stated that the home also had an emergency drug supply room where they stored emergency controlled drug substances located in a specified location of the home.

Inspector #687 conducted an interview with RPN #111 in relation to emergency drug supply storage in the home. RPN #111 stated that the emergency drug supply was kept in a locked box in a cupboard. Together with RPN #111, Inspector #687 observed that the emergency stock box was single-locked.

Inspector #687 conducted an interview with RPN #112 in relation to the emergency drug supply storage in the home. RPN #112 stated that the emergency drug supply was kept in a cupboard and was in a locked box. RPN #112 verified that the emergency stock box was single-locked. The RPN further stated that the emergency drug supply storage box should be double-locked, but that it was not.

In an interview with the DOC, they stated that the emergency supply box was located in a specified area of the home. The DOC further stated that the emergency supply storage box contained controlled substances and was locked. After showing the emergency supply storage box to the Inspector, the DOC recognized that it was not in a double-locked stationary cupboard as it was supposed to be for safe drug storage. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #12: 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 were administered to residents in accordance with directions for use specified by the prescriber.

In a record review of the home's quarterly medication incident report, Inspector #687 identified that on a specified date, a medication incident was reported involving RPN #117, who omitted two medications that were ordered for resident #029.

Inspector #687 conducted a record review of the home's policy titled "Resident Rights, Care and Services – Medication Management – Administration of Medications" last revised July 20, 2017, which indicated that at the time of medication administration, the Registrant will apply the rights of medication administration including:
- The right resident (verified by two resident identifiers);
- The right medication;
- The right reason;
- The right dose;
- The right frequency;
- The right route;
- The right site;
- The right time.

The Medication Management: Administration of Medications also indicated that the registrant document the administration of medications on the Medication Administration Record.

In an interview with RPN #111, they stated that prior to administering a medication to a resident, the registered staff must ensure that the medication would be provided to the right resident, right dose, right time, right route and right medication prescribed by the physician. The RPN further stated that these rights need to be adhered at all times as indicated in the home's policy under "Medication Administration".

In an interview with Co-DOC #102, who was also the Medication Lead for the home, they verified that on the specified date, a medication incident was submitted to them due to dose omission of two medications at 0800 hours by RPN #117 for resident #029. Co-DOC #102 stated that the medication incident report was investigated and analyzed and it was determined that RPN #117 did not follow the policy as stated in the medication administration. [s. 131. (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 to ensure that drugs were administered to residents in accordance with directions for use specified by the prescriber, to be implemented voluntarily.

WN #13: 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 has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

During the initial tour and during subsequent observation, Inspector #647 observed the following:

- On a specified home area, the public resident washroom contained unlabelled hip protectors, and the floor of the shower room had two urine hats.

- On a specified home area, the public resident washroom contained two urine hats on the back of the toilet, storage caddy with one used unlabelled safety razor and a used deodorant. The shower room contained one used unlabelled brush and a used unlabelled hair pick, two used unlabelled deodorants, one unlabelled used razor and the tub room contained two used unlabelled brushes.

- On a specified home area, the linen cart in the entrance of the home area contained one used unlabelled brush and the shower room contained two used unlabelled hair picks and one used unlabelled brush.

- Residents #027, #039, and #040, were wearing glasses that were unlabelled.

During an interview with PSW #106, they indicated that all personal items belonging to residents were to be labelled.

A review of the home's "Resident Rights, Care and Services – Nursing and Personal Support Services – Personal Aids" policy, indicated that Registered staff were to provide direction to ensure that the personal aids of the resident, including glasses were labelled upon admission and as new personal aid items were acquired. Additionally, in the same policy, the PSW's were to ensure that the personal aids of the resident, such as glasses, were labelled upon admission and as new personal aid items were acquired.

Inspector #647 interviewed Co-DOC #122, who confirmed that staff were to ensure that all personal items were labelled. [s. 37. (1) (a)]

WN #14: 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff.

Resident #032 was identified as having altered skin integrity through an MDS assessment.

Inspector #687 completed a record review of resident #032's skin assessments for a specific three month period of time. The Inspector identified that skin assessments were not completed on two specified dates.

The Inspector reviewed the homes policy titled "Resident Rights, Care and Services – Required Programs – Skin and Wound Care Program" last revised February 28, 2018, which indicated that a resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

In an interview with RN #115, they verified that resident #032 had altered skin integrity and that the resident had a weekly assessments completed by RNs or RPNs.

In an interview with the Wound Care Lead, they stated that their expectation from their registered staff members was to complete the skin assessments as scheduled. [s. 50. (2) (b) (iv)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident: a missing or unaccounted for controlled substance.

Inspector #687 reviewed the medication incident reports for the three month period of time. It was identified on a Medication Incident Form that on a specified date, RPN #123 reported that a medication was missing and presumed lost in the garbage.

The Inspector reviewed the Ministry of Health and Long-Term Care's (MOHLTC) online critical incident reporting portal and identified that a CIS report had not been submitted to the Director regarding the missing medication.

Inspector #687 reviewed the policy entitled "Resident Rights, Care and Services – Medication Management – Narcotics and Controlled Substances", last revised October 7, 2013. The policy outlined that the DOC was to initiate and complete a CIS report to the MOHLTC.

In an interview with the DOC and Co-DOC #102, they indicated that, according to the Medication Incident Form, a previous DOC (DOC #168) was notified of the missing medication. The DOC and Co-DOC #102 both stated that DOC #168 should have completed the CIS report within one business day of receiving the Medication Incident Form. [s. 107. (3) 3.]

Issued on this 10th 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) :	STEPHANIE DONI (681), JENNIFER BROWN (647), JENNIFER LAURICELLA (542), LOVIRIZA CALUZA (687), MICHELLE BERARDI (679)
Inspection No. / No de l'inspection :	2018_657681_0025
Log No. / No de registre :	026108-17, 026992-18, 029568-18, 029569-18, 029570-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 28, 2018
Licensee / Titulaire de permis :	Orillia Long Term Care Centre Inc. c/o Jarlette Health Services, 5 Beck Boulevard, PENETANGUISHENE, ON, L9M-1C1
LTC Home / Foyer de SLD :	Leacock Care Centre 25 Museum Drive, ORILLIA, ON, L3V-7T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Matt Lamb

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

To Orillia Long Term Care Centre Inc., 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. 6. (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Order / Ordre :

The licensee must be compliant with s. 6 (9) (1) of the Long Term Care Homes Act (LTCHA).

Specifically, the licensee must

a) ensure that the provision of the care set out in the plan of care is documented.

b) develop and implement a process to ensure that staff are completing documentation as per the home's policies and procedures.

c) conduct audits to ensure that documentation is being completed as required, and maintain a record of the audits that are conducted.

Grounds / Motifs :

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

The home submitted a CIS report to the Director related to an unexpected death of resident #014. Refer to WN #1, Part Three of Inspection Report #2018_657681_0025 for details.

Inspector #647 reviewed documentation from a specified assessment completed after resident #014's fall, which indicated that on three separate occasions staff had not documented the specified assessment as scheduled.

During an interview with Inspector #647, Co-DOC #122 reviewed the documentation for resident #014 and acknowledged that there were gaps in the documentation for the specified assessment. Co-DOC #122 further indicated that the staff should have been documenting at the scheduled intervals for the specified assessment.

2. Two CIS reports were submitted to the Director outlining allegations of resident to resident sexual abuse. The first CIS report was submitted for an incident that occurred where resident #006 was directing a sexual behaviour towards resident #007. The second CIS report was submitted for a similar incident that occurred approximately one month later.

Inspector #542 completed a review of resident #006's health care record. The progress notes included documentation which indicated that the home had instituted a specified intervention for resident #006.

Inspector #542 reviewed documentation of the specified intervention for a specific 45 day time period. It was observed by the Inspector that on 22 of the 45 days, the documentation for the specified intervention was incomplete.

Inspector #542 interviewed Co-DOC #102 and Co-DOC #122 regarding the documentation for the specified intervention. Co-DOC #102 and Co-DOC #122 both verified that the documentation was incomplete.

3. A CIS report was submitted to the Director about an incident that occurred involving resident #015, which resulted in resident #015 sustaining an injury.

Inspector #647 reviewed resident #015's health care record, which indicated that they had been admitted to the home on a specified date and had immediately began to exhibit specific behaviours. The health care record further indicated that resident #015 was transferred to another home area to reduce their safety risk and a specified intervention was also initiated.

Inspector #647 reviewed the documentation for the specified intervention for a specific six week time period. The Inspector was unable to identify consistent documentation for the specified intervention. The records indicated that the

documentation was incomplete on 12 separate dates within the six week time period.

During an interview with Co-DOC #122, a review of the above indicated documentation for resident #015 was conducted. Co-DOC #122 acknowledged the gaps in documentation for the required intervention and further indicated that the staff should have been documenting at the required intervals.

4. A CIS report was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health status. The CIS report identified that resident #013 fell and sustained an injury.

Inspector #679 reviewed resident #013's health record and identified documentation for a specified intervention. It was identified that on five occasions, the documentation for the intervention was blank. In addition to the blank documentation, there were six other occasions in which the document identified that the specified intervention had not been completed.

In an interview with RPN #117, they identified that the specified intervention was completed in specific circumstances. Together, Inspector #679 and RPN #117 reviewed the documentation for this resident and RPN #117 identified that it was the expectation that the documentation be completed.

In an interview with Co-DOC #102, they identified that the specified intervention would be completed in specific circumstances. Together, Inspector #679 and Co-DOC #102 reviewed the documentation for resident #013. Co-DOC #102 confirmed that it was the expectation that the documentation was completed.

5. A complaint was submitted to the Director outlining concerns regarding the falls that resident #005 had sustained. The complaint identified that resident #005 was supposed to receive a specified intervention, but that staff did not complete this intervention due to short staffing.

a) Inspector #679 reviewed resident #005's health care record and identified that the specified intervention was to be completed and there were specific instructions for staff who completed this intervention. Inspector #679 identified

that documentation for this specified intervention was not completed on six occasions.

In an interview with PSW #157, they identified that if a resident was receiving the specified intervention, it would be documented in the resident's health care record. Together, Inspector #679 and PSW #157 reviewed the documentation and PSW #157 confirmed that it was the expectation that this documentation be completed.

In an interview with RPN #148, they identified that if a resident was receiving the specified intervention, it would be documented in the resident's health care record. Together, Inspector #679 and RPN #148 reviewed the documentation and RPN #148 confirmed that it was the expectation that the documentation was completed on each shift.

b) Inspector #679 reviewed resident #005's health care and identified four forms for the documentation of another specified intervention. The Inspector identified that on a total of 16 occasions, there was blank documentation within the four forms.

In an interview with RPN #117, they identified that a specified intervention was completed in specific circumstances. Together, Inspector #679 and RPN #117 reviewed the forms for this resident. RPN #117 identified that it was the expectation that the documentation be completed.

In an interview with Co-DOC #102, they identified that the specific intervention was completed in specific circumstances. Together, Inspector #679 and Co-DOC #102 reviewed the documentation. Co-DOC #102 confirmed that it was the expectation that the documentation be completed.

The severity of this issue was determined to be a level three, as there was actual harm/risk. The scope of the issue was a level two, as there was a pattern identified with the residents reviewed. The home had a level three compliance history, as they had related non-compliance with this section of the LTCHA that included:

- a voluntary plan of correction (VPC) issued February 22, 2016,

(#2015_298557_0019); and
- a written notification (WN) issued June 21, 2017, (#2017_646618_0011). (647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 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 : 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. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8 (1) (b) of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee must

a) ensure that there is an organized program of personal support services for the home to meet the assessed needs of the residents.

b) review the staffing plans for each Home Area to ensure that the planned staffing levels meet the needs of the residents in the home, and maintain a record of this review.

c) ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice.

Grounds / Motifs :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Two CIS reports were submitted to the Director outlining allegations of resident to resident sexual abuse. Please refer to WN #1, Part Five of Inspection Report #2018_657681_0025 for details.

Inspector #542 reviewed resident #006's health care record. It was documented in the care plan and in the progress notes that the home had implemented a specified intervention for resident #006 after the first incident occurred. Inspector #542 was unable to locate any further documentation to indicate that the home had discontinued the specified intervention for resident #006.

During an interview with the Administrator, they indicated that resident #006 was to have the specified intervention implemented on the date the second incident occurred. However, the home did not have a full complement of staff working on that date and staff members had to be re-assigned. As a result, the specified intervention for resident #006 was not implemented on the date the second incident occurred.

2. Four complaints were submitted to the Director regarding the staffing levels in the home. During the inspection, residents #021, #045, #046, and #047 also reported that they did not believe that the home had sufficient staff to provide them the care and assistance that they required.

a) Inspector #542 reviewed the "bathing/toileting" audit tool from a specified home area for a particular date. It was documented that residents #016, #043 and #044 received a bed bath.

The Inspector reviewed the progress notes for residents #016, #043 and #044. For all three residents it was documented "scheduled bath day, bed bath offered."

A review of resident #016's current electronic care plan was completed. It was documented that the resident preferred a shower. Resident #043's current care plan revealed that they were to be offered a tub bath or shower and to let the resident choose. Resident #044's current care plan indicated that they preferred a shower.

Inspector #647 interviewed PSW #109, who indicated that the specified home area did not have a full complement of PSW staff on the particular date. PSW #109 further stated that two of the scheduled baths/showers (for residents #016 and #043) were not completed as a result of short staffing.

b) Inspector #679 reviewed the progress notes in resident #012's health care record and identified that on another specified date, RPN #148 documented that staff were unable to give resident #012 their bath due to short staffing.

The Inspector identified that that there was no documentation regarding resident #012's bath in the resident's health care record for the specified date. The next documented bath was three days later.

Inspector #679 reviewed the documentation with RPN #148. RPN #148 identified that when a resident's bath was missed, staff would "make a note for the day staff to do [the resident's] bath on the next shift".

3. A CIS report was submitted to the Director for an incident that caused injury to a resident for which the resident was taken to hospital and that resulted in a significant change to the resident's health status. Please refer to WN #4, Part One of Inspection Report #2018_657681_0025 for additional details.

Inspector #679 reviewed the home's internal investigation related to the incident, which included documentation from an interview with PSW #140. The documentation indicated that PSW #140 identified that the home was short staffed on the date of the incident, that PSW #140 was not familiar with the residents, and that there was not a second staff member assisting PSW #140.

In an interview with PSW #137, they identified that they were working when resident #012's fall and injury occurred. PSW #137 identified that a specified device had been used improperly to transfer resident #012.

In an interview with the DOC, they identified that staff were to follow the home's policy when transferring residents using the specified device.

4. Resident #023's family member indicated that resident #023 required a specific intervention for all transfers and that the resident was frequently transferred incorrectly. Please refer to WN #4, Part Two of Inspection Report #2018_657681_0025 for additional details.

Inspector #542 interviewed PSW #127, who indicated that they often transferred

resident #023 incorrectly due to short staffing.

Inspector #542 interviewed the Restorative Care Coordinator, who was responsible for assessing residents for their transferring ability, along with the Physiotherapists. They confirmed that resident #023 was to have a specified intervention for all transfers.

The severity of this issue was determined to be a level two, as there was minimal harm or the potential for actual harm. The scope of the issue was a level two, as a pattern was identified throughout the home. The home had a level two compliance history, as they did not have a history of related non-compliance with this section of the LTCHA. (542)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 28, 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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).

Order / Ordre :

The licensee must be compliant with s. 53 (4) (b) of the Ontario Regulation 79/10.

Specifically, the licensee must

a) ensure that for each resident demonstrating behaviours that strategies are developed and implemented to respond to these behaviours.

b) conduct a review of all residents who exhibit behaviours to ensure that strategies have been implemented, and maintain a record of this review.

Grounds / Motifs :

1. The licensee has failed to ensure that strategies had been developed and implemented to respond to the resident that demonstrated responsive behaviours.

A CIS report was submitted to the Director about an incident that had occurred involving resident #015. Please refer to WN #1, Part Six of Inspection Report #2018_657681_0025 for further details.

Inspector #647 reviewed resident #015's health care records, which indicated that resident #015 began to exhibit specified behaviours immediately following

their admission to the home.

A review of the plan of care for resident #015 indicated that it was initiated when the resident was admitted to the home. The Inspector identified that the initial plan of care included the resident's specified behaviours, as well as, three initial interventions.

A review of the progress notes indicated that resident #015 continued to exhibit the specified behaviours on eight separate occasions prior to the incident for which the CIS report was submitted.

A further review of the plan of care for resident #015 indicated that there had not been any further strategies developed or implemented to respond to the resident's specified behaviours.

During a meeting with the Administrator, they acknowledged that specified behaviours were identified when resident #015 was admitted to the home. Documents reviewed included a new admission email that was sent to the management team which identified that resident #015 was known to exhibit specified behaviours, as well as a multidisciplinary care conference note, which indicated resident #015 was a particular safety risk. The Administrator further acknowledged that there had been no new strategies developed or implemented to address the resident's specified behaviours since the resident was admitted to the home.

The severity of this issue was determined to be a level two, as there was minimal harm or the potential for actual harm. The scope of the issue was a level one, as it only related to one resident. The home had a level three compliance history, as they had related non-compliance with this section of the Ontario Regulation 79/10 that included:

-a voluntary plan of correction (VPC) issued April 7, 2016, (#2016_334565_0004) (647)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 28, 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with s. 36 of the Ontario Regulation 79/10.

Specifically, the licensee must

a) ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

b) develop and implement a process to ensure that staff are kept aware of the level of assistance required by residents for transferring.

c) perform audits to ensure that direct care staff are using safe transferring techniques and maintain a record of the audits that are completed.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

A CIS report was submitted to the Director for an incident that caused injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health status. The CIS report identified that a PSW improperly used a device to transfer resident #012, which resulted in the resident sustaining a fall that resulted in injury.

Inspector #679 reviewed the home's internal investigation related to the incident and identified an account of the incident completed by DOC #138. The statement identified that PSW #140 improperly used a device to transfer resident #012. The home's internal investigation file also contained

documentation, which identified that the home was short staffed on the date of the incident, that PSW #140 was not familiar with residents, and that there was not a second staff member assisting PSW #140 at the time of the incident.

In an interview with PSW #137, they identified that they were working when resident #012's fall occurred. PSW #137 identified that they had heard yelling, and found resident #012 on the floor. PSW #137 identified that the device used to transfer resident #012 had not been used correctly.

In an interview with the DOC, they identified that the staff member had not transferred resident #012 as per the home's policy.

2. During an interview with Inspector #542, resident #023's SDM stated that the staff were not transferring resident #023 appropriately. Resident #023's SDM indicated that the resident required a specified intervention for all transfers and that the resident was frequently transferred improperly. Furthermore, during the interview, Inspector #542 observed a PSW improperly transfer resident #023.

A review of resident #023's health care record was completed by Inspector #542. The current care plan identified that resident #023 required a specified intervention for all transfers.

On a second occasion, Inspector #542 observed PSW #142 improperly transfer resident #023. On a third occasion, the Inspector observed PSW #143 improperly transfer resident #023.

During an interview with PSW #142, they indicated that they typically used a particular method to transfer resident #023 because it was easier and the resident became agitated when this method was not used.

During an interview with PSW #143, they indicated that they were unaware of what resident #023's care plan indicated regarding transfer interventions.

During an interview with PSW #127, they indicated that they often transferred resident #023 using a particular method due to short staffing. They further indicated that it was easier to transfer resident #023 using this method.

Inspector #542 interviewed the Restorative Care Lead, who was responsible for assessing residents for their transferring ability, along with the Physiotherapists. They confirmed that resident #023 was assessed and was to be transferred with a specified intervention.

The severity of this issue was determined to be a level three, as there was actual harm/risk to resident #012. The scope of the issue was a level two, as a pattern was identified with the residents reviewed. The home had a level two compliance history, as they did not have any previous non-compliance with this section of the Ontario Regulation 79/10. (679)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2019

Order # / Ordre no : 005

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. (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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must be compliant with s. 6 (10) (b) of the Long Term Care Homes Act (LTCHA).

Specifically, the licensee must

a) 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 the resident's care needs change or care set out in the plan is no longer necessary.

b) review the care plans for all residents who are at high risk of falls to ensure the care plans reflect the falls prevention interventions that are being implemented.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care was 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 was no longer necessary.

A CIS report was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health status. The CIS report identified that

resident #011 fell and sustained an injury.

Inspector #679 reviewed the progress notes in resident #011's health care record, which identified that the resident had a previous fall on a specified date. The progress note, written by the Restorative Care Coordinator, identified that the staff would trial the use of a specified intervention to prevent further falls.

The Inspector reviewed the resident's care plan and identified that the use of the specified intervention was not documented in the care plan.

A review of the policy entitled "Resident Rights, Care and Services- Plan of Care- Plan of Care" last updated March 13, 2018, identified that the plan of care shall be reviewed and revised when the resident's care needs changed, the care set out in the plan was no longer necessary, or the care set out in the plan had not been effective.

In an interview with Inspector #679, RPN #111 identified that staff would reference a resident's care plan to determine which fall prevention interventions were in place. Inspector #679 reviewed the progress note, which indicated that staff would trial the use of the specified intervention to prevent further falls. RPN #111 identified that this intervention should have been listed in the care plan. Together, Inspector #679 and RPN #111 reviewed the electronic care plan, and identified that the use of the specified intervention was not outlined in the care plan.

In an interview with the DOC, they identified that staff would reference a resident's care plan to determine fall prevention interventions. Together, Inspector #679 and the DOC reviewed the progress notes and care plan in the resident's health care record. The DOC identified that the use of the specified intervention was not included in the care plan and stated that, if it was something being trialed, then it should be included in the care plan.

2. A CIS report was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health status. The CIS report identified that a PSW improperly used a specified device to transfer resident #012, which resulted in the resident sustaining an injury.

Inspector #679 observed resident #012 with a specified falls prevention intervention in place on several occasions.

In an interview with PSW #127, they identified that resident #012 had a specified falls prevention intervention. PSW #127 identified that these interventions would be identified in the resident's care plan.

Inspector #679 reviewed resident #012's current care plan, which did not identify the use of the specified falls prevention intervention.

Inspector #679 reviewed an electronic progress note, which indicated that resident #012 was provided with the specified falls prevention intervention on a specific date.

In an interview with RPN #148, they identified that resident #012 had a specified intervention in place to prevent falls and that falls prevention interventions would be outlined in the care plan. Together, Inspector #679 and RPN #148 reviewed the resident's current care plan and did not identify the use of the specified intervention.

In an interview with the Restorative Care Coordinator, they identified that this resident had a specified intervention in place to prevent falls and that falls prevention interventions should be listed in the care plan. The Inspector and Restorative Care Coordinator reviewed the electronic care plan and identified that the use of the specified intervention was not outlined in the care plan.

Together, Inspector #679 and the DOC reviewed the care plan and the DOC identified that the falls prevention intervention should have been inputted into the care plan when it was initiated.

3. A CIS report was submitted to the Director for an incident that caused injury to a resident, for which the resident was taken to hospital and that resulted in a significant change in the resident's health status. The CIS report identified that resident #013 fell and sustained an injury.

Inspector #679 reviewed the resident's health care record and identified that

resident #013 sustained a specified number of falls prior to the fall with injury. The Inspector identified a progress note, which indicated that the Restorative Care Coordinator had suggested that staff implement a specified intervention to decrease the risk of falls. The Inspector also identified a second progress note, which indicated that the Restorative Care Coordinator provided resident #013 another specified falls prevention intervention.

Inspector #679 reviewed the care plan and identified that neither of the interventions were listed in the resident's care plan.

Together, Inspector #679 and the Restorative Care Coordinator reviewed the resident's care plan and progress notes. The Restorative Care Coordinator identified that they did not see the interventions listed in the care plan.

Together, Inspector #679 and Co-DOC #102 reviewed resident #013's care plan and did not observe the interventions listed in the care plan. Co-DOC #102 stated that the interventions should have been included in the resident's care plan.

4. A complaint was submitted to the Director outlining concerns about the falls that resident #005 sustained.

In an interview with the RPN #117, they identified that resident #005 used a specified intervention to prevent falls.

Inspector #679 reviewed the care plan for this resident and identified that the use of the intervention was not included in the resident's care plan.

In an interview with the Restorative Care Coordinator, they identified that resident #005 had a specified intervention to prevent falls. Together, Inspector #679 and the Restorative Care Coordinator reviewed resident #005's care plan. The Restorative Care Coordinator identified that the use of the specified intervention was not in this resident's care plan, and that this intervention should have been listed in the care plan.

In an interview with Co-DOC #102 they identified that fall prevention interventions would be listed in the care plan. Together, Co-DOC #102 and

Inspector #679 reviewed the electronic care plan. Co-DOC #102 confirmed that they did not see the use of the specified falls prevention intervention outlined in resident #005's care plan.

5. During an interview with Inspector #542, resident #023's SDM indicated that the home was not following the resident's care plan.

Inspector #542 completed a review of resident #023's current care plan and identified that a specified falls prevention intervention was listed in the care plan.

An interview was conducted with the home's Restorative Care Coordinator, who was also the lead for the Falls Prevention Committee. They indicated that resident #023 no longer used the specified intervention because it was posing a safety risk to the resident. The Restorative Care Coordinator further confirmed that the care plan had not been revised.

The severity of this issue was determined to be a level two, as there was minimal harm or the potential for actual harm. The scope of the issue was a level two, as there was a pattern identified with the residents reviewed. The home had a level two compliance history, as they did not have related non-compliance with this section of the LTCHA. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 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 28th day of December, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Stephanie Doni

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