Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 16, 2017	2016_405189_0020	032941-16	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Langstaff Square Care Community
170 Red Maple Road RICHMOND HILL ON L4B 4T8

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

NICOLE RANGER (189), VERON ASH (535)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 23, 24, 28, 29, 30, December 1, 2, 5, 7, 2016.

The following intakes were inspected concurrently during this Resident Quality inspection (RQI): Critical Incident (CI) intakes related to medication: #033318-15, follow up order related to dietary: #013601-16.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC) Assistant Director of Care (ADOC), Program and Support Service Manager, Food Service Manager (FSM), Environmental Service Manager (ESM), Registered Dietitian, Food Service Supervisor (FSS), Residents' Council President, Activation Aide, registered staff, housekeeping aide, personal support workers, residents and family members.

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration, infection prevention and control practices, meal and snack service delivery, reviewed clinical health records, minutes of Residents' Council and Family Council meetings, minutes of relevant committee meetings, and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Family Council
Food Quality
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **14 WN(s)**
- **6 VPC(s)**
- **1 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
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2016_321501_0004	189
LTCHA, 2007 S.O. 2007, c.8 s. 6. (2)	CO #002	2016_321501_0004	535
O.Reg 79/10 s. 71. (5)	CO #003	2016_321501_0004	535

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and shall ensure that residents were not neglected by the licensee or staff.

During an interview with resident #022 on an identified date, he/she stated that an incident occurred with registered staff #132 who was the charge nurse on the unit where he/she resided. The registered staff came to the resident's room to check on him/her, and asked the resident if he/she wanted to hear a joke. Although the resident told the charge nurse that he/she did not want to hear the joke; the registered staff proceeded to recite the joke for the resident to hear. According to the resident, he/she told the registered staff to leave his/her room because the joke was upsetting and inappropriate. The resident stated that a few days after the incident occurred, he/she informed the Director of Care #109 of the incident. The resident also stated that since he/she reported the incident to the Director of Care, the registered staff does not speak to the resident directly. The registered staff would communicate with the resident through the Health Forces Ontario (HFO) nurse who is training with registered staff #132.

According to the resident, the HFO nurse administered all his/her medication since the incident occurred. The first time the charge nurse communicated with the resident was on an identified date. During an interview with registered staff #132, he/she confirmed that the incident occurred. The registered staff also confirmed that he/she told the resident the joke; that he/she were aware that resident #022 was upset because of the content of the joke; and that he/she kept their distance from the resident and had very little interaction with the resident since he/she was looking for a better way to communicate with the resident while continuing to work on the unit.

During an interview with the Director of Care #109, he/she confirmed that the resident reported the incident related to the joke being told by the registered staff; however both the DOC and the Executive Director #127 were surprised to hear of the statements made by the charge nurse related to the resident. The Director of Care stated that the staff would be off work immediately pending an investigation. During the interview, the Director of Care also stated that the registered staff should have been cognizant of their professional therapeutic relationship. The Director of Care also acknowledged that this incident constituted abuse of the resident. [s. 19. (1)]

2. Resident #005 was admitted to the home with an identified medical condition requiring a g-tube insertion. Record review noted that the resident was coded as an independent, consistent and reasonable decision-maker. During an interview with resident #005, he/she stated that if he/she refused to take the prescribed medications as ordered by mouth, the registered staff would administer the medication by the g-tube instead. The resident also stated that he/she felt their decision was not respected by the staff.

Record review of the resident's plan of care showed that the medication was to be administered by g-tube only under particular circumstances. During interviews with registered staff #123 and #125, both staff stated that on occasion, if the resident refused to the take his/her prescribed medication even after being informed of the consequences of refusing consent, they proceeded to administer the medications by the resident's g-tube site instead of by mouth. Both registered staff also confirmed that administering the medication in the g-tube when the resident refused the medication does not acknowledge the resident's right to refuse consent to be administered the medication. The ADOC #108 stated during an interview that administering the medication by g-tube after the resident refused the medication did not respect the resident's choice of refusing consent. Registered staff #123 and #125 ignored or failed to acknowledge the resident's capacity to refuse care or treatment when they administered the medication by the g-tube.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.
The home failed to take appropriate actions to protect resident #005 and resident #022 from abuse.
The scope of the non-compliance is isolated to Resident #005 and Resident #022. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully communicated and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

During an interview with resident #002's family member, he/she reported that there were a few times where he/she found staff members personal coat and purse located in the resident's closet.

Interview with RPN #118, reported that resident #002's family member voiced their concerns about a staff members personal coat and purse inside the resident closet. RPN #118 reported that he/she went into the resident's room and observed PSW #117's personal coat and purse inside the resident's room. RPN #118 reported that he/she informed PSW #117 not to place his/her personal belongings inside the resident's closet. Interview with PSW #117 confirmed that there were multiple times when he/she placed her personal coat and purse inside the resident closet.

RPN #118 and PSW #117 confirmed that staff placing their personal belongings inside resident #002 closet did not treat the resident with dignity and respect. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the following rights of residents are fully communicated and promoted: Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

On an identified date, during an interview, registered staff #132 reported to the inspector that he/she had privately recorded a conversation between him/herself and resident #022 on his/her voice recorder on a personal cell phone without the resident's knowledge or consent. During an interview with the Director of Care #109 and the Executive Director #127, the DOC stated that it was inappropriate for the staff to record the resident privately without his/her knowledge, and that the incident would be further investigated. [s. 3. (1) 8.]

3. The licensee has failed to ensure that the following rights of residents are fully communicated and promoted: Every resident has the right to keep and display personal possession, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.

During an interview with resident #002's family member, he/she reported that during the

summer, the resident's planter which was located on the window sill, was taken out of his/her room and placed inside the activity room.

Interview with the activation aide #119, reported that during the summer, housekeeping staff #128 had taken the resident's planter out of his/her room and placed the planter in the activity room. Activation Aide #119 reported that he/she was unaware the planter belonged to resident #002, and placed a plant in the planter out on the patio. Activation Aide #119 reported that it was after the resident's annual care conference that he/she was informed by the Program Manager #113 that the family had reported the planter missing and if the activation aide can put back the planter in the resident's room. Interview with the Activation Aide #119 and the DOC confirmed that staff removing the planter of the of the resident's room was inappropriate. [s. 3. (1) 10.]

4. The licensee has failed to ensure that the following rights of residents are fully communicated and promoted: Every resident has the right to participate fully in the development, implementation, review and revision of his or her plan of care, ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent.

During an interview with resident #005, he/she informed the inspector that he/she was currently taking numerous pills daily; and that he/she was currently administered an elixir medication at a specific time which had a terrible taste. Record review revealed that the resident's cognitive status was listed as independent with decisions consistent and reasonable.

During an interview with registered staff #125 he/she reported that the resident had made a comment on taking too many medications, and that the resident did mention the poor taste of the elixir; however the resident's concerns with his/her medications were not addressed by the staff until after the registered staff heard the concerns from the inspector. A review of the resident's care plan revealed that there were no listed preferences/likes included although staff members were able to state many of the resident's preferences. During interviews, registered staff #123 and #125 confirmed that the resident's care plan did not reflect his/her preferences related to taking medication in a different form. Both staff also agreed that the resident had not been provided the opportunity to participate fully in the development, implementation and revision of his/her care plan. [s. 3. (1) 11. i.]

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 following rights of residents are fully communicated and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, Every resident has the right to keep and display personal possession, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents, and Every resident has the right to participate fully in the development, implementation, review and revision of his or her plan of care, ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that different aspects of care were integrated and were consistent with and complemented each other.

During an interview with resident #003's family member, he/she reported that during the resident's six week care conference with the home's care team , the family reported that the resident does not like particular food items, and the family request that these items not be served. The family reported to the inspector that after the care conference was conducted, the home still continued to provide resident #003 these food items.

Record review of resident #003's written plan of care did not indicate the food preference. Review of the diet sheet located in the kitchen servery, indicated the resident food preference.

Interview with Food Service Supervisor #126 (FSS), who was present during the six week care conference, confirmed that the family discussed the resident's food preference. The FSS reported that he/she noted this preference on the diet sheet located in the kitchen servery, however he/she did not communicate this food preference to the Registered Dietitian (RD). Interview with the RD confirmed that he/she was unaware of the resident's food preference and the written plan of care was not updated. Interview with PSW #110, who is the primary PSW for the resident, revealed that he/she was unaware of the resident's food preference. Interview with the Food Service Manager confirmed that the changes to the resident's food preference was not communicated to the team. [s. 6. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On an identified date and time, the inspector entered into resident #037's room and observed the resident lying down in bed. Upon closer observation, the inspector observed an injury on an identified part of the resident's body. PSW #115 entered into the room and informed the inspector that during morning care, he/she proceeded to provide care and accidently injured the resident.

The inspector left and returned back to the room 15 minutes later and observed the resident in the same manner. The inspector left the room and called RPN #114 to observe the resident. The RPN assessed the resident. PSW #115 entered into the room and informed the RPN what had occurred during morning care. RPN #114 instructed PSW #115 to apply a treatment to the resident.

A review of the home's policy entitled " Observation and Monitoring Records – PSW Documentation", revised January 2015, directs the personal support workers to notify registered staff of any resident change in status.

Interview with PSW #115, revealed that he/she intended to let RPN #114 know about the resident's injury at the end of his/her shift. Interview with RPN #114 reported that the PSW should have informed him/her immediately once the injury occurred.

Interview with RPN #114 and the DOC confirmed that PSW #115 did not report the injury, and should of reported the injury immediately to the registered staff. [s. 8. (1) (b)]

2. On an identified date, the MOHLTC received a complaint regarding missing controlled substance for resident #021.

A review of the home's Narcotic and Controlled Substances Administration Record policy #04-07-10 dated on June 23, 2014, showed that a check of the balance-on-hand must be done by two registered staff or care providers as per facility policy at the time of every shift change. The count and each signature were recorded in the appropriate column on the Narcotic and Controlled Substances Administration Record. The policy also indicated that once per month, the facility staff was to perform a monthly audit of the narcotic and controlled substances administration record to determine if there were discrepancies; and that discrepancies must be reported to the Director of Nursing/Care as soon as they were discovered. Interviews were conducted with registered staff #123, 125 and #120 related to a medication incident involving missing controlled substances that occurred on an identified date.

During the interviews, the registered staff all confirmed that on occasion, the narcotic and controlled substances were counted by only one registered staff at the end of the shift; and once the oncoming second registered staff completed the count again, he/she would sign the narcotic and controlled substance record at a later time at the beginning of their shift.

A review of the identified unit narcotic and controlled substance record showed that a bottle of controlled substance was noted to be missing the morning of an identified date at 0700 hours by the oncoming registered nurse #123; and was discovered placed in the double locked narcotic bin the morning of an identified date at 0700 hours, again by the oncoming registered staff #123 when he/she went to complete the narcotic count.

During the interview, registered staff #123 stated that on an identified date at 0700 hours and on an identified date at 0700 hours, two registered staff from the night and day shifts did not perform the narcotic count together as stated in the home's policy. Record review and staff interview confirmed that registered staff #123 discovered the missing medication at 0700 hours on the identified date after the night registered staff #120 had already left the building. However the missing controlled substance was not reported to the Director of Care until after 1500 hours on the identified date by both the out-going day shift registered staff #123 and the on-coming evening shift registered staff #125.

During an interview, the DOC confirmed that the incident of missing controlled substance should have been reported immediately upon discovery. A review of the home's Narcotic and Controlled Substances Administration Record policy #04-07-10 dated June 23, 2014, indicated that all entries must be made at the time the drugs were removed from the double locked narcotic bin in the medication cart and administered to each resident.

During an interview with registered staff #120, he/she indicated that they usually arrive to work early for their shift and prepare/pre-pour medications to be administered during their shift. The registered staff also stated that he/she usually placed the medications in a small basket; and that he/she used the basket to transport medications to residents' rooms for administration instead of taking the med cart. Registered staff #120 medication pre-pouring practice was also confirmed as witnessed by registered staff #125 during change of shift. During an interview with the DOC, he/she confirmed that registered staffs #120, 123, and 125 did not follow the home's narcotic and controlled substances administration record policy. [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Record review and staff interview revealed that resident #007 was identified with altered skin integrity on an identified date. Record review of the skin assessments for resident #007 revealed that weekly skin assessments were not conducted for two months after the altered skin integrity developed, until a secondary altered skin integrity developed.

Interviews with RPN #114 confirmed that the weekly skin assessments were not conducted for identified dates for the resident with altered skin integrity. [s. 50. (2) (b) (i)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint.

During an interview with resident #022, he/she informed the inspector that on an identified date, during an activity program in the home, the facilitator of the program made a comment to the group which the resident viewed as inappropriate. The resident stated that he/she was very upset when the facilitator made a comment which was related to the number of culturally specific residents in the room. The resident stated he/she reported the incident to the previous program manager who no longer worked in the home. The current Program Manager #113 was not aware of the complaint until after the resident informed the inspector. During an interview with the current program manager, he/she stated that they reviewed the documents and records left by the previous program manager but was unable to locate any documentation of the resident's complaint.A review of the progress notes and the home's complaint and concern binder revealed that the incident was not documented, investigated or followed up by any member of the staff in the home.

During an interview with resident #022, he/she informed the inspector that on an identified date, an incident occurred with registered staff #132 on the unit where he/she resided in the home. The registered staff told the resident a joke which the resident thought was upsetting and inappropriate. According to the resident, he/she told the staff to leave his/her room, and reported the incident to the Director of Care #109. The resident further stated that the results of the investigation and outcome of the incident was not brought back to him/her by the DOC; and that he/she thought that the registered nurse should apologized for the incident. A review of the progress notes and investigations note provided by the DOC revealed that the incident occurred.

During an interview the DOC, he/she stated that he/she saw the resident downstairs in the lobby and called him/her aside and informed him/her that they had followed up with the registered staff. The inspector observed that the incident was not documented in the home's complaint and concern binder. During a follow up interview with the resident on an identified date, he/she stated that they were just informed this morning that the registered staff was discipline related to the incident; however the resident also stated that the staff could have been disciplined for anything and that he/she was still waiting for an apology from the registered staff related to what was said during the incident. [s. 101. (1) 1.]

2. The licensee has failed to ensure that a document record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

During an interview with resident #002's family member, he/she reported that there were a few times where he/she found staff members personal coat and purse located in the resident's closet. The family member also reported that during the summer, the resident's planter which was located on the window sill, was taken out of her room and placed inside the activity room.

Interview with RPN #118 revealed that resident #002's family member did voice their concerns about staff members personal coat and purse inside the resident closet. RPN #118 reported to the inspector that he/she did not document the incident , fill out a complaints record, nor notify the DOC of the family members concerns, as he/she reported he/she spoke with PSW #117 about the incident.

Interview with Program Manger #113, revealed that during the annual care conference held on an identified date, he/she was informed by the family member concern of the missing planter. The Program Manager informed the inspector that he/she did not document the family member concern nor fill out a complaints record.

Interview with the DOC confirmed that the staff should have report all family concerns to the management and fill out a complaints records as required. [s. 101. (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 every verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and ensure that a document record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

WN #7: 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 failed 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.

On an identified date, the MOHLTC received complaint intake regarding missing controlled substance for resident #021. Record review of the identified unit narcotic and controlled substance record revealed that the controlled substance was discovered missing by registered staff #123 on an identified date at 0700 hours. However, the staff did not report the medication missing until the beginning of the evening shift on an identified date, sometime after 1500 hours when the amount of missing controlled substance was measured and confirmed. At that time, both registered staff #123 and #125 reported the missing controlled substance to the DOC, and registered staff #123 completed a medication incident report.

During interviews, the DOC and both registered staff confirmed that the controlled substance was missing from the double locked narcotic bin within the medication cart for approximately 24 hours, until the missing bottle of medication was discovered placed back into the doubled locked narcotic bin within the medication cart by registered staff. Therefore, the controlled substance was not stored in a separate double-locked area of the medication cart for 24hrs between an identified time period. [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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation that could potentially trigger such altercations.

On an identified date, while conducting an interview for resident #022, he/she provided information which led to the follow up and review of resident #023's behavior in the home.

Record review indicated that resident #023 was assessed to be modified independence with some difficulty in new situations. The record also showed that the resident ambulates with the use of mobility devices sometimes; cognitive functions varies, and that the resident can become easily annoyed. A review of the progress notes revealed multiple documented episodes by the resident towards care-givers and other residents; and progress notes entry noted the resident's behaviors included striking out with his/her mobility device toward another resident.

During an interview with registered staff #128, he/she stated that the above documentation was correct; and that the resident did threatened to hit another resident with his/her mobility device. The staff continued that he/she could not recall the reason for the resident's behaviors towards the other resident, and that the incident was reported to the oncoming registered staff but not to management because the incident occurred late in the evening shift. PSW #131 who provided primary care for the resident stated during an interview that they are concerned because the resident sometimes displayed behaviors.

During an interview, registered staff #130 stated that he/she also heard the resident making threats, however the resident had not been assessed or referred to the physician or external resources for consultation related to his/her behavior. The registered staff further stated that the resident does require an assessment with behavior support put in place to prevent or minimize the risk of altercations and potentially harmful interactions between residents . [s. 54. (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids were prepared, stored, and served using methods which preserve taste, nutritive value, appearance and food quality.

Record review revealed that resident #006 was practicing a particular faith and adhered to related dietary preferences. A review of the dietary plan and the resident's care plan revealed that the resident was to be offered meals accommdating the dietary preference. During an interview with the resident, he/she revealed dissatisfaction with the quality of the meals being offered. The resident further stated that he/she had been refusing the meals accommodating the dietary preferences and eating from the regular menu because of the poor taste and quality of the food. According to the resident, he/she has spoken to the FSM # 100 and the Registered Dietitian #107 about the poor food quality but that they both ignored his/her complaint.

During an interview, the FSM stated that the home tried conducting a taste test to compare two different vendors of these particular menu items; and that resident # 006 preferred the home's vendor therefore they stock with those meals going forward; the FSM also stated that the issue could be the repetition of meals for lunch and supper related to the limited choices of the particular meals. [s. 72. (3) (a)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports for the past two year were posted in the home.

During the initial tour of the home, the inspector observed that the following inspection report and compliance orders were not posted in the home: 2016_321501_0004 dated April 1, 2016. During an interview with the Executive Director #127, he/she stated that this report and orders were posted in the home the day after the Resident Quality Inspection started in the home. [s. 79. (3) (k)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for, (a) cleaning of the home, including, (i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces.

On an identified date, the inspector observed resident #001's privacy curtains to be visibly soiled. Interview with resident #001 revealed that the privacy curtains were not cleaned or changed since he/she was admitted to the home on an identified date.

Record review of the home' s policy titled " Privacy Curtains & Drapes – Housekeeping", revised January 2015, directs the housekeeping staff to check and clean curtains and draperies on a daily and yearly basis, and housekeeping staff to inspect curtains during daily cleaning for stains, missing hooks, or repairs.

Interview with the Environmental Service Manager (ESM), revealed that the home has a monthly painting and curtain washing schedule, where each resident room is scheduled one day during the year to have painting and curtain washing completed. In addition to the monthly schedule, there is a housekeeping blitz conducted twice a year where the housekeeping staff will remove and clean all window and privacy curtains.

The inspector requested documentation for the 2016 painting and curtain washing schedule. The inspector reviewed the documentation, and there were no schedule in place for resident #001 curtains to be cleaned. Interview with the ESM confirmed that the resident's room was not on the scheduled to be cleaned. On an identified date, observation of resident #001's privacy curtain by the ESM confirmed that the privacy curtains was visibly soiled and does not appear to be cleaned by the housekeeping staff. [s. 87. (2) (a)]

2. The licensee has failed to ensure that as part of the organized program of housekeeping, procedures are developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

On an identified date, the inspector observed resident #002's wheelchair to be visibly soiled. On an identified date, the inspector observed resident #038's chair to be visible soiled. The inspector observed resident #002's wheelchair for a period of three days on an identified dates, during which the wheelchair continued to be in the same manner and visibly soiled.

The inspector reviewed the wheelchair cleaning schedule for the residents. The wheelchair for resident #002 was scheduled to be cleaned on an identified date, and the chair for resident #038 was scheduled to be cleaned on an identified date.

Staff interviews revealed that the wheelchairs are cleaned by the night staff as per schedule, and the home's process is to take the wheelchairs to the shower room for cleaning.

Interview with PSW #104 revealed that he/she cleaned resident #002's wheelchair on an identified date, however, interview and observations by RPN #106 and the DOC confirmed that the wheelchair was visibly soiled and does not appear to be cleaned by staff.

Interview with PSW #105 revealed on the night of an identified date, although he/she documented that he/she cleaned resident #038's wheelchair, he/she in fact did not clean the resident's wheelchair as he/she forgotten to do so. Interview and observation by the DOC confirmed that resident #038's chair was visibly soiled and does not appear to be cleaned by the staff. [s. 87. (2) (b)]

WN #12: 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to 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): A missing or unaccounted for controlled substance.

On an identified date, the MOHLTC received the complaint intake regarding missing controlled substance for resident #021. Record review and staff interviews revealed that on an identified date and time a bottle of controlled substance, went missing from the narcotic and controlled substances double-locked bin; and that the bottle was discovered to be placed in the double-locked narcotic and controlled substance bin the next morning on an identified date.

During an interview with the Director of Care #109, he/she stated that they did not report the controlled substance missing because the missing medication was found within a 24 hour period. [s. 107. (3)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the annual evaluation of the medication management system must, (a) include a review of the quarterly evaluations in the previous year as referred to in section 115; (b) be undertaken using an assessment instrument designed specifically for this purpose; and (c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices

The inspector requested the home's 2015 quarterly and annual evaluation of the medication management system. The Executive Director (ED) #127 presented the minutes for the quarterly Professional Advisory Committee meeting for an identified date The minutes were reviewed and the incident of missing controlled substance which occurred on an identified date was not included in the quarterly summary reports.

The ED also produced a Quality Management - LTC Program/Committee Evaluation Tool which was dated February 25, 2016 and listed a review period from January 2015 to December 31, 2015. The annual evaluation minutes indicated that the document was to be used for the annual review of the Medication Management System and Emergency Drug Supply, however not all required persons were present for the meeting. The only participants listed on the annual evaluation minutes were the DOC #109 and ADOC #108 and ADOC #134. As well, the evaluation minutes did not identify changes to improve the medication management system. Therefore, the annual evaluation of the medication management system did not include a review of the quarterly evaluations and the minimum required interdisciplinary team membership. [s. 116. (3)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, and that corrective action were taken as necessary, and a written record was kept of everything required under clauses (a) and (b).

On an identified date, the MOHLTC received a complaint regarding missing controlled substance for resident #021. During interviews with registered staff, the Director of Care, and a review of the medication incident report completed by registered staff #123 on an identified date; the documentation and incident report showed that the missing controlled substance was discovered to be missing from the double-locked narcotic bin on an identified date at 0700 hours. The bottle was relocated and placed in the double locked narcotic bin, and the amount count back into the total balance remaining on an identified date at 0700 hours.

A review of the medication incident report revealed that the report form had incomplete information related to who was notified of the incident, additional facts were not completed with only a general statement stating medication was found on an identified home area by night staff, there was no signature from the Pharmacy Manager as required on the document, and the section to be completed by the Pharmacy was left blank including the name and who had been notified sections.

The medication incident report form also included a section related to Facility Evaluation which contained corrective action to be included; and whether a response was completed in a timely manner. Both areas of the document were left blank. The report form was signed by the home's DOC #109. The medication incident record did not include a review and analysis, as well as corrective actions to be taken by the home related to this incident. [s. 135. (2)]

Issued on this 22nd day of February, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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) :	NICOLE RANGER (189), VERON ASH (535)
Inspection No. / No de l'inspection :	2016_405189_0020
Log No. / Registre no:	032941-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 16, 2017
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	Langstaff Square Care Community 170 Red Maple Road, RICHMOND HILL, ON, L4B-4T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dwayne Green

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that the home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. The plan will include but not limited to the following:

Develop a plan to educate staff and implement steps to ensure that all staff respect resident #005's ability to make their own decision regarding their care, including medication administration.

Develop a plan to educate staff and implement steps to ensure that all residents in the home are protected from abuse and/or neglect by the staff, including training on the home's abuse policies, types of abuse, power imbalances and cultural sensitivity.

The licensee shall maintain a record of re-training provided including dates, times, attendees,trainers and material taught.

The plan to be submitted via email to nicole.ranger@ontario.ca by March 2, 2017

Grounds / Motifs :

1. The licensee failed to ensure that residents were protected from abuse by anyone and shall ensure that residents were not neglected by the licensee or staff.

Resident #005 was admitted to the home with an identified medical condition requiring a g-tube insertion. Record review noted that the resident was coded as

an independent, consistent and reasonable decision-maker. During an interview with resident #005, he/she stated that if he/she refused to take the prescribed medications as ordered by mouth, the registered staff would administer the medication by the g-tube instead. The resident also stated that he/she felt their decision was not respected by the staff.

Record review of the resident's plan of care showed that the medication was to be administered by g-tube only under particular circumstances. During interviews with registered staff #123 and #125, both staff stated that on occasion, if the resident refused to the take his/her prescribed medication even after being informed of the consequences of refusing consent, they proceeded to administer the medications by the resident's g-tube site instead of by mouth. Both registered staff also confirmed that administering the medication in the g-tube when the resident refused the medication does not acknowledge the resident's right to refuse consent to be administered the medication. The ADOC #108 stated during an interview that administering the medication by g-tube after the resident refused the medication did not respect the resident's choice of refusing consent. Registered staff #123 and #125 ignored or failed to acknowledge the resident's capacity to refuse care or treatment when they administered the medication by the g-tube. (535)

2. During an interview with resident #022 on an identified date, he/she stated that an incident occurred with registered staff #132 who was the charge nurse on the unit where he/she resided. The registered staff came to the resident's room to check on him/her, and asked the resident if he/she wanted to hear a joke. Although the resident told the charge nurse that he/she did not want to hear the joke; the registered staff proceeded to recite the joke for the resident to hear. According to the resident, he/she told the registered staff to leave his/her room because the joke was upsetting and inappropriate. The resident stated that a few days after the incident occurred, he/she informed the Director of Care #109 of the incident. The resident also stated that since he/she reported the incident to the Director of Care, the registered staff does not speak to the resident directly. The registered staff would communicate with the resident through the Health Forces Ontario (HFO) nurse who is training with registered staff #132.

According to the resident, the HFO nurse administered all his/her medication since the incident occurred. The first time the charge nurse communicated with the resident was on an identified date. During an interview with registered staff

#132, he/she confirmed that the incident occurred. The registered staff also confirmed that he/she told the resident the joke; that he/she were aware that resident #022 was upset because of the content of the joke; and that he/she kept their distance from the resident and had very little interaction with the resident since he/she was looking for a better way to communicate with the resident while continuing to work on the unit.

During an interview with the Director of Care #109, he/she confirmed that the resident reported the incident related to the joke being told by the registered staff; however both the DOC and the Executive Director #127 were surprised to hear of the statements made by the charge nurse related to the resident. The Director of Care stated that the staff would be off work immediately pending an investigation. During the interview, the Director of Care also stated that the registered staff should have been cognizant of their professional therapeutic relationship. The Director of Care also acknowledged that this incident constituted abuse of the resident.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.
The home failed to take appropriate actions to protect resident #005 and resident #022 from abuse.
The scope of the non-compliance is isolated to Resident #005 and Resident #022.
(535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 28, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
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 and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 16th day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : NICOLE RANGER

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