Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 7, 2015 | 2015_331595_0004 | S-000727-15 | Resident Quality Inspection |

### Licensee/Titulaire de permis

584482 ONTARIO INC
689 YONGE STREET MIDLAND ON L4R 2E1

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

MANITOULIN LODGE
3 MAIN STREET P. O. BOX 648 GORE BAY ON P0P 1H0

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

MARINA MOFFATT (595), JENNIFER LAURICELLA (542), LINDSAY DYRDA (575)

### 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): March 3 - 6, 9 - 13, 2015**

**The following Ministry of Health and Long-Term Care logs were inspected concurrently: S-000512-14, S-000502-14, S-000443-14, S-000596-14, S-000597-14, S-000747-15.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered and Non-Registered Staff, RAI-MDS Coordinator, Restorative Care Coordinator, Environmental Services, Dietary Staff, Residents and Family Members.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #001.

On March 4, 5, and 6, 2015 resident #001 was observed tilted in their wheelchair. Inspector #575 reviewed the resident's health care record which did not identify the use of a tilt wheelchair.

On March 6, 2015 inspector interviewed s#-100 and s#-101 who stated that the resident required the use of a tilt wheelchair for comfort measures. The resident's kardex was reviewed by s#-100 and the care plan by s#-101, who both confirmed that the use of the tilt wheelchair was not identified.

On March 9, 2015 Inspector #575 interviewed the DOC who stated that the use of a tilt wheelchair should be included on the resident's care plan. The DOC reviewed the resident's electronic care plan with the inspector. It was noted that the use of a tilt wheelchair was now included in the resident's care plan. The DOC stated that it was added on March 6, 2015 by s#-103. The DOC also pointed out that the care plan indicated that the resident was dependent in a 'Gerichair', however this was incorrect and should instead read 'wheelchair'. The DOC updated the care plan as a result.

On March 9, 2015 s#-100 approached Inspector #575 and stated that after their interview on March 6 they advised the Administrator that the tilt wheelchair was missing from the resident's care plan. The staff member informed the inspector that 'it is fixed now'.

On March 10, 2015 the inspector interviewed s#-103. The staff member confirmed that the tilt wheelchair was previously missing from the care plan and was added once they became aware. [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #024.

During stage one of the RQI, Inspector #542 observed resident #024 in a tilted wheel chair. On March 5, 2015, Inspector #542 reviewed the most recent care plan and noted that there was nothing regarding the use of a tilted wheel chair for this resident. Inspector #542 also reviewed the resident's health care record and was unable to locate any documentation regarding use of the wheelchair or it's purpose for this resident.

Inspector #542 interviewed s#-104 who stated that they were unaware if the resident even used a wheelchair. Inspector also spoke with three different Personal Support Workers (PSWs) who were unclear if the resident used the wheel chair or when it was to be tilted. [s. 6. (1) (c)]

3. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #004.

On March 6, 2015 Inspector #575 observed s#-101 administer oral medication to resident #004. The staff member administered eight medications; five medications were crushed, one capsule was opened, and two medications were not crushed. The medications were administered to the resident in chocolate pudding.

The inspector reviewed the resident's plan of care. The inspector noted that the plan of care did not include directions to crush the resident's medications and administer with pudding.

Inspector #575 asked s#-101 how they knew to crush the resident's medication and administer them in chocolate pudding. The staff member stated that in a past conversation with the resident's family, it was identified that resident #004 liked chocolate pudding, and that this practice was effective previously. The staff member confirmed that these directions should be documented in the care plan, however upon review of resident #004's care plan, s#-101 could not locate this information.

On March 11, 2015, the inspector interviewed s#-105 regarding resident #004's

medication administration. The staff member stated that they crush some of the resident's medications and administer them usually in applesauce, pudding, or jam. The staff member stated that the resident's medications are crushed because the resident will spit out their medications. The staff member stated that they know to crush the medications as the resident's family had advised them of this. The staff member stated that this direction should be in the resident's plan of care.

The resident's written plan of care did not provide clear directions to staff to crush the resident's medications and administer with chocolate pudding or applesauce. [s. 6. (1) (c)]

4. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #021.

Inspector #595 reviewed the care plan for resident #021 on March 12, 2015 on PointClickCare. An intervention was identified in the care plan, under the focus of ‘care deficit’, that directed staff to provide a treatment as ordered by the physician. Upon review of the physician’s orders and Treatment Administration Record (TAR), it was noted than an order for the treatment could not be located.

Inspector #595 spoke with s#-105 who confirmed that resident #021 the treatment ordered in February but had been discontinued. The staff member showed inspector the February Medication Administration Record (MAR) that identified that the treatment was ordered. Since that time, the resident has used an alternative treatment, however the initial treatment was still identified in resident #021's care plan. [s. 6. (1) (c)]

5. The licensee failed to ensure that the care set out in residents' #025 and #028 plan of care was provided to the resident as specified in the plan.

Inspector #542 reviewed the health care record for resident #028. The most recent RAI-MDS assessment revealed that the resident had memory impairment, was moderately impaired for decision making and exhibited some behavioral symptoms such as wandering. The most current care plan indicated that resident #028 wandered due to a cognitive impairment. In the care plan it identified that resident #028 required one staff to escort them to and from the dining room and activities and assist the resident to locate their room. It was also noted that staff were to redirect resident #028 should they start to exhibit inappropriate behaviours.

On March 12, 2015 at 0951h, Inspector #542 and #575 observed resident #028 to leave the dining room after breakfast. There were no staff walking with the resident. Resident #028 was observed to go into another resident's room, but then wandered back out. Additionally, Inspector #542 had observed other instances throughout the inspection where resident #028 ambulated to and from the dining room without staff supervision. Inspector #542 spoke with s#-111 who confirmed that the resident wanders, but typically does not enter any of the other resident's rooms. [s. 6. (7)]

6. Inspector #542 completed a health care record review for resident #025. The most recent care plan outlined five interventions that staff were to implement when the resident exhibited inappropriate behaviour.

On March 11, 2015 Inspector #542 observed resident #025 ambulating beside another female co-resident down a corridor unsupervised. No staff were observed to re-direct the resident away from the female resident. [s. 6. (7)]

***Additional Required Actions:***

***CO # - 001 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 the care set out in the plan of care for residents #025 and #028 is provided to the residents as specified in the plan, to be implemented voluntarily.***

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there is at least one Registered Nurse (RN), who is an employee of the licensee and a member of the regular nursing staff, on duty and present at all times.

Inspector #595 spoke with the DOC who stated that the home does not have an RN on-site at all times. The DOC stated that on days when there is no RN, a Registered Practical Nurse (RPN) would be used as a replacement. The DOC also identified that on the RN schedule it should have a day, evening and night shift scheduled, however there are some shifts that are left blank because there was no RN to work the shift.

Inspector #595 reviewed the RN schedule for February 22 - March 7, 2015 and the following shifts did not have an RN on duty and present in the home:
February 22 - evening and night shift
February 24 - evening shift
February 25 - day shift
February 26 - day shift
February 27 - evening shift
February 28 - day shift
March 1 - day shift
March 2 - day shift
March 4 - day shift
March 5 - day shift
March 7 - day shift [s. 8. (3)]

***Additional Required Actions:***

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

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents were protected from abuse by resident #025.

On March 6th, 2015, Inspector #542 reviewed a Critical Incident (CI) report that was submitted to the Director for resident-to-resident abuse. The CI revealed that s#-106 had witnessed resident #028 enter resident #025's room and then reported this to s#-107, who entered the room and found resident #025's hand under resident #028's shirt. According to the CI, resident #028 appeared upset and was crying.

Inspector #542 interviewed s#-106 who stated that they witnessed resident #025 standing at the doorway to their room. Resident #025 then started to guide resident #028 into the room by touching resident #028 by the hand. The staff member informed s#-107 who then intervened.

Inspector #542 spoke with s#-107 who stated that after s#-106 informed them of what was witnessed, they proceeded to resident #025's room and found resident #025 to have their hand under resident #028's shirt. The staff member also indicated that resident #028 appeared upset and was crying. The staff member then separated the residents and reported the incident to one of the managers. The staff member stated that resident #025 has been known to take other residents into their room, although the resident typically attempts to do this with staff.

Inspector #542 completed a health care record review for resident #025. The most recent care plan outlined five interventions that staff were to implement when the resident would demonstrate inappropriate behaviours.

On March 11, 2015 Inspector #542 observed resident #025 ambulating beside another female co-resident down a corridor unsupervised. No staff were observed to re-direct the resident away from the female resident.

Inspector #542 spoke with the DOC who stated that resident #025 was easily redirected; that they are not to be put in a group setting; and that they seldom seek out other female residents. The DOC also explained that the resident had a history of touching females in an inappropriate manner.

Inspector #542 reviewed resident #025's progress notes which revealed numerous

incidents of inappropriate behaviors towards staff and visitors. In one instance, prior to the submission of this CI, it was documented by s#-108 that resident #025 was inappropriate in a physical manner with another female resident. Inspector spoke with the DOC and Administrator who both stated that they were not aware of this incident. The progress notes did not reveal any specifics about the incident and it was not reported to management or the Director of the MOHLTC. Inspector #542 spoke with s#-108 who stated that they did not witness the incident and it was reported to them by a PSW staff member. S#-108, stated that they were almost 100% sure that resident #025 had physically touched a co-resident's (female) breasts. The staff member could not recall why they did not report the incident or the name of the staff member that reported the incident to them. S#-108 acknowledged that the documentation of the incident should have been much more detailed.

Inspector #542 spoke with s#-109 and s#-110 who worked on the same shift as when this incident occurred. One staff, s#-109, stated that they could not recall the specific incident on that day as there have been some other incidents where resident #025 has been 'touchy' with family members and staff. The other staff member, s#-110, recalled an incident where resident #025 was inappropriately touching a resident while both residents were sitting in the front lounge, however the staff was unsure if it was the same incident. This staff member was also able to recall another incident where resident #025 had resident #028 in their room and was inappropriately touching them.

Inspector #542 spoke with s#-111 who stated that they were responsible for managing the Responsive Behaviour Committee Meetings, updating care plans, meeting with Behavioural Supports Ontario (BSO), and completing referrals to BSO. The staff member stated that BSO had been involved with resident #025’s care for approximately 2-3 months.

Inspector asked s#-111 if there was a copy of BSO report, and the staff member stated that they had not received the written report yet. The staff member informed inspector that the BSO team provided the home with some suggestions verbally on how to minimize resident #025’s inappropriate behaviour, including monitoring and distraction. BSO also recommended the use of a specific piece of equipment which would alert the staff when someone enters the room or when resident #025 leaves the room. The staff member stated that the home currently does not have one that resident #025 could use. BSO also suggested other interventions however the home had not implemented them at the time of this inspection.

Inspector #542 reviewed the Responsive Behaviour Meeting Minutes which indicated that there was no improvement in resident #025's behaviour over a five-month period, BSO had been integrated into the resident's care, and different interventions had been discussed.

Inspector #542 was informed by s#-111 that the home completed one-week DOS charting on two separate occasions to document resident #025's behaviours. Inspector #542 reviewed the DOS charting for these two weeks which revealed several gaps in the documentation. During one of the weeks, over a 6-day span there was no documentation between 0730 – 1400 and four days had no documentation from 0730 – 2200.

Inspector reviewed the health care record for resident #028. The most recent RAI-MDS assessment revealed that the resident had short and long-term memory impairment, was moderately impaired for decision making and exhibited some behavioral symptoms such as wandering. The most current care plan indicated that resident #028 wandered due to a cognitive impairment. In the care plan it identified that resident #028 required one staff to escort them to and from the dining room and activities and assist the resident to locate their room. It was also noted that staff were to redirect resident #028 should they start to disrobe or take items.

On March 12, 2015 at 0951h, Inspector #542 and #575 observed resident #028 to leave the dining room after breakfast. There were no staff walking with the resident. Resident #028 was observed to go into another resident's (male) room, but then wandered back out. Additionally, Inspector #542 had observed other instances throughout the inspection where resident #028 ambulated to and from the dining room without staff supervision. Inspector #542 spoke with s#-111 who stated that BSO staff are not assigned to resident #028 as the resident only wanders and typically does not enter any of the other resident's rooms. [s. 19. (1)]

2. The licensee failed to protect residents from abuse by s#-112.

Inspector reviewed a CI that was submitted to the Director regarding staff-to-resident abuse. The CI alleged that s#-112 was mean to resident #029 and that they had called them a name. Resident #029 had reported this to s#-113 who in turn reported it to s#-104. The staff member, s#-104, did not immediately report this incident to management or the Director.

On March 11, 2015, Inspector #542 interviewed resident #029 about the incident. The

resident stated that when s#-112 had assisted them to the shower, they had complained that the water was cold and then s#-112 called them a 'baby'. The resident stated that they didn't feel as though the staff member should have said that, and at the time they thought that maybe they shouldn't have said anything about the shower being cold. The resident also stated that maybe they shouldn't have said anything because they don't want to get anyone in trouble.

Inspector #542 spoke with the Administrator who stated that an investigation had been conducted for this incident and that the file had been sent to the home's Human Resource Director to be finalized. The Administrator stated that they felt that s#-112 would be terminated. At the beginning of the investigation, s#-112 was suspended. The Administrator also stated that s#-104 received a written warning because they did not report the incident of abuse immediately to management.

On March 12, 2015, Inspector #542 spoke with s#-113, who stated that resident #029 informed them that s#-112 always calls them a 'baby'. The resident also reported that the comment by s#-112 upset them. S#-113 spoke with another resident who informed the staff member that s#-112 is not very nice to them. This information was reported to s#-114 at the end of shift on the same day that resident #029 reported it.

Inspector #542 reviewed s#-112's employee file which did not reveal additional incidents of staff-to-resident abuse. It was noted that the staff member received training on Prevention of Abuse, Neglect, Retaliation and Resident Rights in 2014. They also received training on Gentle Persuasive Approach (GPA). The education file for s#-104 was also reviewed and indicated that the staff member received training on the same during general orientation in 2014. [s. 19. (1)]

3. In the same CI report submitted, it was documented that s#-112 had also been abusive towards another resident #024, by placing their hand over the resident’s mouth in an attempt to quiet them down.

Inspector #542 interviewed s#-114 who stated that they had entered resident #024’s room where s#-115 was providing care to resident #024. S#-112 entered the room and told the resident to 'sssshhhh' and covered the resident’s mouth with their hand. This was witnessed by s#114 who, initially, did not feel that this was abusive and did not report the incident immediately. The staff member explained to inspector that they now understand that it was not appropriate for s#-112 to do that, and that the incident should have been reported immediately. Inspector #542 was informed by the Administrator that s#-114

received a letter of discipline for not reporting the incident of abuse immediately.

Inspector #542 completed a health record review for resident #024 which indicated that the resident had responsive behaviours, was severely impaired for decision making and they required extensive-total assistance by 1-2 staff for Activities of Daily Living (ADL). [s. 19. (1)]

***Additional Required Actions:***

***CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.***

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

Inspector #542 reviewed the home's policy 'Resident Rights, Care and Services - Abuse - Zero Tolerance - Staff Acknowledgement'. The policy indicated that a staff member of the home who has reasonable grounds to suspect abuse or neglect of a resident must immediately report their suspicion to the most senior administrative personnel on site at the home.

Inspector #542 reviewed resident #025's progress notes which revealed that on an evening shift in February 2015, s#-108 had documented that resident #025 was inappropriate in a physical manner with another female resident. Inspector #542 spoke with the DOC and Administrator who both stated that they were not made aware of this incident. Inspector #542 spoke with s#-108 who stated that they did not witness the incident and it was reported to them by a PSW staff member. The staff member stated that they were almost 100% sure that resident #025 had physically touched the co-resident's breasts. The staff member could not recall why they did not report the incident or the name of the staff member that reported the incident to them. They acknowledged that the documentation of the incident should have been much more detailed. [s. 20. (1)]

2. Inspector #542 reviewed a Critical Incident (CI) report that was submitted to the Director regarding staff-to-resident abuse. Resident #029 reported to s#-113 that s#-112 always calls them a 'baby' and that this upsets them. Another resident informed s#-113 that s#-112 is not very nice to them. This information was reported to s#-104 at the end of shift on February 27, 2015. Inspector #542 spoke with the Administrator who stated that s#-104 did not report this immediately to management, and that the DOC found out the next day as a note was left regarding the incident. The Administrator also stated that s#-104 received a written warning for not reporting the abuse immediately.

In the same CI report, it was identified that another resident #024, was also allegedly abused by s#-112 as witnessed by s#-114. According to the CI, s#-112 had placed their hand over resident #024's mouth trying to 'shhhh' the resident. Inspector spoke with s#-114 who acknowledged that they did not report it immediately. Inspector #542 spoke with the Administrator who stated that s#-114 did not report this incident immediately and that the DOC found out the next day as a note was left regarding the incident. The Administrator also stated that s#-114 received a written warning for not reporting the abuse immediately. [s. 20. (1)]

***Additional Required Actions:***

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

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the staffing plan included a back-up plan for 24/7 Registered Nurse (RN) coverage that addresses situations when staff cannot come to work.

Inspector #595 requested the home's staffing plan from the Administrator. Upon review of the plan, it was noted that it did not identify a back-up plan for 24/7 RN coverage.

Inspector #595 spoke with the DOC who stated that the home does not have a written back-up staffing plan for RNs. [s. 31. (3)]

***Additional Required Actions:***

***CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,**
**(i) within 24 hours of the resident's admission,**
**(ii) upon any return of the resident from hospital, and**
**(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).**

**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 resident #003 received a skin assessment by a member of the registered nursing staff within 24 hours of admission.

Inspector #575 spoke with the the DOC (Skin and Wound Care Lead) who stated that upon admission, each resident received a head-to-toe skin assessment that was entered

into PointClickCare (PCC) found under the assessments tab. The DOC confirmed that resident #003 did not receive a head-to-toe skin assessment until eight days after admission. The DOC stated that the head-to-toe skin assessment should be completed within 24 hours of admission and that resident #003's assessment was completed late. [s. 50. (2) (a) (i)]

2. The licensee has failed to ensure that resident #003 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Inspector #575 reviewed resident #003's health care record. The inspector noted that the resident's RAI-MDS assessment indicated that the resident had three wounds.

Inspector #575 interviewed the DOC (Skin and Wound Lead) regarding resident #003's wounds. The DOC reviewed the resident's progress notes which identified the presence of three wounds. The DOC stated that residents with altered skin integrity receive a 'Wound Assessment and Treatment' assessment which is entered into PCC under the assessment tab. The DOC reviewed the resident's health care record and confirmed to the inspector that the resident did not receive an assessment. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that residents #003 and #042 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspector #595 reviewed the health care record for resident #042. It was noted that the resident had one wound. Upon review of the physician's orders, it was identified that there was an order for the resident's wound to be assessed weekly. Inspector #595 spoke with s#-101 and s#-104 who stated that wound assessments are to be completed weekly, using the designated progress note in PCC.

Inspector #595 reviewed the progress notes in PCC which revealed three instances where weekly wound assessments were not completed. Inspector reviewed assessments in PCC and found that there were no completed assessments entered during these three weeks. In one instance, the inspector identified a note that commented on the resident's wound, however an assessment was not completed. [s. 50. (2) (b) (iv)]

4. Inspector #575 reviewed resident #003's health care record. The inspector noted that the resident's RAI-MDS assessment indicated that the resident had three wounds.

The inspector interviewed the DOC (Skin and Wound Lead) regarding resident #003's wounds. The DOC reviewed the resident's progress notes which identified the presence of three wounds. The DOC stated that staff are required to complete a wound or skin progress note weekly on Wednesdays when a resident exhibits altered skin integrity. The DOC confirmed that there was only wound note for resident #003, and weekly reassessments were not completed.

Inspector #575 reviewed the home's policy titled 'Resident Rights, Care and Services - Skin and Wound Care Program' effective September 16, 2013 which indicated that when a resident has actual alteration in skin integrity registered staff are to complete a wound or skin progress note weekly. [s. 50. (2) (b) (iv)]

***Additional Required Actions:***

***CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that actions were taken to respond to the needs of resident #025, including assessments, reassessments and interventions and that the

resident's responses to interventions were documented.

Inspector #542 reviewed a Critical Incident (CI) report that was submitted to the Director for resident-to-resident abuse. The CI revealed that s#-106 had witnessed resident #028 enter resident #025's room and then reported this to s#-107, who entered the room and found resident #025's hand under resident #028's shirt. According to the CI, resident #028 appeared upset and was crying.

Inspector #542 interviewed s#-106 who stated that they witnessed resident #025 standing at the doorway to their room. Resident #025 then started to guide resident #028 into the room by touching resident #028 by the hand. The staff member informed s#-107 who then intervened.

Inspector #542 spoke with s#-107 who stated that after s#-106 informed them of what was witnessed, they proceeded to resident #025's room and found resident #025 to have their hand under resident #028's shirt. The staff member also indicated that resident #028 appeared upset and was crying. The staff member then separated the residents and reported the incident to one of the managers. The staff member stated that resident #025 has been known to take other residents into their room, although typically attempts to do this with staff.

Inspector #542 spoke with the DOC who stated that resident #025 was easily redirected; that they are not to be put in a group setting; and that they seldom seek out other female residents. The DOC also explained that the resident has a history of touching females in an inappropriate manner.

Inspector #542 completed a health care record review for resident #025. The most recent care plan outlined five interventions that staff were to implement when the resident exhibited inappropriate behaviour.

On March 11, 2015 Inspector #542 observed resident #025 ambulating beside another female co-resident down a corridor unsupervised. No staff were observed to re-direct the resident away from the female resident.

Inspector #542 reviewed resident #025's progress notes which revealed numerous incidents of inappropriate and responsive behaviors towards staff and visitors. There was documentation that identified numerous sexually inappropriate and responsive behaviours by resident #025. In one instance, the police were called.

Inspector #542 spoke with s#-109 and s#-110 who worked on the same shift as when the incident between resident #025 and #028 occurred. S#-109 stated that they could not recall the specific incident on that day as there have been some other incidents where resident #025 has been 'touchy' with family members and staff. S#-110 recalled an incident where resident #025 was inappropriately touching another resident while both residents were sitting in the front lounge, however the staff was unsure if it was the same incident. This staff member was also able to recall another incident where resident #025 had resident #028 in their room and was touching them in a sexual manner.

Inspector #542 spoke with s#-111 who stated that they were responsible for managing the Responsive Behaviour Committee Meetings, updating care plans, meeting with Behavioural Supports Ontario (BSO), and completing referrals to BSO. The staff member stated that BSO had been involved with resident #025's care for approximately 2-3 months. Inspector asked s#-111 if there was a copy of a BSO report, and the staff member stated that they had not received the written report yet. The staff member informed inspector that the BSO team provided the home with some suggestions verbally on how to minimize resident #025's sexually inappropriate behaviour, including monitoring and distraction. BSO also recommended that the home use a specific piece of equipment which would alert the staff when someone enters the room or when resident #025 leaves the room. The staff member stated that the home currently does not have one that resident #025 could use. BSO also suggested other interventions however the home had not implemented them at the time of this inspection.

Inspector #524 reviewed the 'Responsive Behaviour Meeting' minutes as provided by s#-111. It was documented over a five-month span that the resident's responsive behaviours did not change or improve. In one meeting, it was documented that resident #025 was not responding to "no" from staff when exhibiting behaviours. On March 10, 2015 Inspector #542 reviewed resident #025's care plan, which indicated that when the resident exhibits sexual behaviours, staff are to use simple direct commands, such as saying 'no'.

Inspector #542 was informed by s#-111 that the home completed one-week DOS charting on two separate occasions to document resident #025's behaviours. Inspector #542 reviewed the DOS charting for these two weeks which revealed several gaps in the documentation. During one week, over a 6-day span there was no documentation between 0730h – 1400h, and four days had no documentation from 0730h – 2200h. [s. 53. (4) (c)]

***Additional Required Actions:***

***CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #8: 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 the home's policy titled 'Resident Rights, Care and Services - Skin and Wound Care - Program' is implemented and complied with.

Inspector #575 reviewed the home's policy titled 'Resident Rights, Care and Services - Skin and Wound Care - Program' effective September 16, 2013. The policy indicated that when a resident has actual alteration of skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, registered staff are required to complete a wound assessment and treatment record, complete a weekly wound or skin progress note to reflect weekly assessments, and refer the resident to a Registered Dietitian (using electronic referral on PCC).

Inspector #575 noted the following documentation in the progress notes for resident #003:
- Physician Note, resident had hit their foot and obtained an abrasion. Treatments were initiated;
- Daily Progress Note, redness noted;
- Physician Note, ongoing erythema and blisters/erosion, treatments changed;
- Physician Note, ongoing shallow ulcerations.

It was not until two months later that there was a documented Wound Note for resident #003's wounds. Inspector #575 spoke with the DOC who confirmed that an initial wound assessment and weekly reassessments were not completed for resident #003's wounds. Inspector also identified a nutritional referral was documented in the progress notes upon admission, as well as two other referrals, however none of them pertained to the resident's altered skin integrity. [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 policy 'Resident Rights, Care and Services - Skin and Wound Care - Program' is implemented and complied with, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care**

**Specifically failed to comply with the following:**

**s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,**
**(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).**
**(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).**
**(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents #021, #023, #041 and #043 were offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident/SDM if payment is required.

Inspector #595 spoke with s#-101 who stated that they were not aware of whether the home offered annual dental assessments to residents. Inspector spoke to the DOC who confirmed that the home does not offer annual dental assessments to residents, and that if residents wished to have an assessment, they would be expected to arrange the appointment on their own. [s. 34. (1) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are offered annual dental assessments and other preventative dental services, subject to payment being authorized by the resident/SDM if payment is required, to be implemented voluntarily.***

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

**Specifically failed to comply with the following:**

**s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

According to resident #002's most recent RAI-MDS assessment, the resident had a respiratory infection. The inspector interviewed the DOC (Infection Prevention and Control lead) regarding the resident's respiratory infection. The DOC stated that the home was recently in a respiratory outbreak from January 2-22, 2015. The DOC stated that when residents experience symptoms of infection, staff are to implement a daily tracking line list, and a note is left in the physician book for assessment. The DOC stated that the symptoms for the respiratory outbreak in January included nasal congestion, cough, or fever. The DOC stated that staff are not required to enter a progress note each shift regarding the symptoms of infection, however they should complete one progress note at least daily.

Inspector #575 reviewed the home's policy titled 'Infection Prevention and Control Surveillance' effective September 16, 2013. The policy indicated that 'registered staff will, on every shift, for those residents with infection or suspected infection, document in the progress notes, using infection note label, regarding the presence or absence of symptoms. Will continue to document for 48 hours after symptoms of infection have subsided, or until 48 hours after antimicrobial completion'.

The inspector noted that the resident was listed on the line listing with a date of onset of December 31, 2014. The resident's symptoms included nasal congestion and cough. The date symptoms were resolved was not indicated on the line listing. The inspector then reviewed the progress notes from December 31, 2014 to January 31, 2015 and noted only three progress notes by registered staff regarding the presence or absence of symptoms, on January 1, 7, 18, 2015.

Inspector #575 interviewed s#-101 who stated that staff should be documenting symptoms each shift, however s#-101 was aware that during the last outbreak there was missing documentation. The staff member stated that there were numerous residents with symptoms. The staff member could not recall how long they are to document the presence of symptoms, and stated that if a resident was on antibiotics, typically staff would document until the antibiotics were completed.

Inspector #575 interviewed s#-104 who stated that if residents have symptoms of infection, they would document their status on the line listing and do their vitals daily. The staff member added that they have never been instructed to do anything specifically, except write the resident's name on the line listing.

The inspector reviewed the physician's orders and resident #002's Medication Administration Record (MAR). The inspector noted that the resident was ordered medication. However upon further review of the daily audit sheet for January, it was noted that the resident was the medication for an alternative reason, not a respiratory infection. [s. 229. (5) (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 staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.***

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**WN #11: 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):**
**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).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident of an environmental hazard that affected the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including a breakdown of major equipment or a system in the home.

Inspector #575 reviewed a Critical Incident (CI) report submitted to the Director on September 22, 2014. The CI indicated that on September 16, 2014 the call bell system malfunctioned and was not working six rooms. The DOC and the Administrator both confirmed that the call bell system was not repaired until September 19, 2014.

The CI was not submitted until September 22, 2014. The Administrator informed Inspector #595 that the CI was submitted late as it was originally 'saved' and not 'submitted'. Once the Administrator realized it was 'saved' they submitted it to the Director. [s. 107. (3) 2.]

**Issued on this 12th day of May, 2015**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

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

## Public Copy/Copie du public

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | MARINA MOFFATT (595), JENNIFER LAURICELLA (542), LINDSAY DYRDA (575) |
| **Inspection No. / No de l'inspection :** | 2015_331595_0004 |
| **Log No. / Registre no:** | S-000727-15 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | May 7, 2015 |
| **Licensee / Titulaire de permis :** | 584482 ONTARIO INC<br>689 YONGE STREET, MIDLAND, ON, L4R-2E1 |
| **LTC Home / Foyer de SLD :** | MANITOULIN LODGE<br>3 MAIN STREET, P. O. BOX 648, GORE BAY, ON, P0P-1H0 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | DEBBIE WRIGHT |

To 584482 ONTARIO 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

**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

**Order # / Ordre no :** 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Linked to Existing Order / Lien vers ordre existant:** 2014_283544_0028, CO #002;

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

**Order / Ordre :**

The licensee shall ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

**Grounds / Motifs :**

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #021.

Inspector #595 reviewed the care plan for resident #021 on March 12, 2015 on PointClickCare. An intervention was identified in the care plan, under the focus of 'care deficit', that directed staff to provide a treatment as ordered by the physician. Upon review of the physician's orders and Treatment Administration Record (TAR), it was noted than an order for the treatment could not be located.

Inspector #595 spoke with s#-105 who confirmed that resident #021 the treatment ordered in February but had been discontinued. The staff member showed inspector the February Medication Administration Record (MAR) that identified that the treatment was ordered. Since that time, the resident has used an alternative treatment, however the initial treatment was still identified in resident #021's care plan. (542)

2. The licensee failed to ensure that the plan of care set out clear directions to

staff and others who provide direct care to resident #004.

On March 6, 2015 Inspector #575 observed s#-101 administer oral medication to resident #004. The staff member administered eight medications; five medications were crushed, one capsule was opened, and two medications were not crushed. The medications were administered to the resident in chocolate pudding.

The inspector reviewed the resident's plan of care. The inspector noted that the plan of care did not include directions to crush the resident's medications and administer with pudding.

Inspector #575 asked s#-101 how they knew to crush the resident's medication and administer them in chocolate pudding. The staff member stated that in a past conversation with the resident's family, it was identified that resident #004 liked chocolate pudding, and that this practice was effective previously. The staff member confirmed that these directions should be documented in the care plan, however upon review of resident #004's care plan, s#-101 could not locate this information.

On March 11, 2015, the inspector interviewed s#-105 regarding resident #004's medication administration. The staff member stated that they crush some of the resident's medications and administer them usually in applesauce, pudding, or jam. The staff member stated that the resident's medications are crushed because the resident will spit out their medications. The staff member stated that they know to crush the medications as the resident's family had advised them of this. The staff member stated that this direction should be in the resident's plan of care.

The resident's written plan of care did not provide clear directions to staff to crush the resident's medications and administer with chocolate pudding or applesauce. (575)

3. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #024.

During stage one of the RQI, Inspector #542 observed resident #024 in a tilted wheel chair. On March 5, 2015, Inspector #542 reviewed the most recent care plan and noted that there was nothing regarding the use of a tilted wheel chair

for this resident. Inspector #542 also reviewed the resident's health care record and was unable to locate any documentation regarding use of the wheelchair or it's purpose for this resident.

Inspector #542 interviewed s#-104 who stated that they were unaware if the resident even used a wheelchair. Inspector also spoke with three different Personal Support Workers (PSWs) who were unclear if the resident used the wheel chair or when it was to be tilted. (542)

4. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #001.

On March 4, 5, and 6, 2015 resident #001 was observed tilted in their wheelchair. Inspector #575 reviewed the resident's health care record which did not identify the use of a tilt wheelchair.

On March 6, 2015 inspector interviewed s#-100 and s#-101 who stated that the resident required the use of a tilt wheelchair for comfort measures. The resident's kardex was reviewed by s#-100 and the care plan by s#-101, who both confirmed that the use of the tilt wheelchair was not identified.

On March 9, 2015 Inspector #575 interviewed the DOC who stated that the use of a tilt wheelchair should be included on the resident's care plan. The DOC reviewed the resident's electronic care plan with the inspector. It was noted that the use of a tilt wheelchair was now included in the resident's care plan. The DOC stated that it was added on March 6, 2015 by s#-103. The DOC also pointed out that the care plan indicated that the resident was dependent in a 'Gerichair', however this was incorrect and should instead read 'wheelchair'. The DOC updated the care plan as a result.

On March 9, 2015 s#-100 approached Inspector #575 and stated that after their interview on March 6 they advised the Administrator that the tilt wheelchair was missing from the resident's care plan. The staff member informed the inspector that 'it is fixed now'.

On March 10, 2015 the inspector interviewed s#-103. The staff member confirmed that the tilt wheelchair was previously missing from the care plan and was added once they became aware. (575)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 05, 2015

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

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**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee shall submit prepare, submit and implement a plan to ensure that there is at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

This plan must be faxed, to the attention of LTCH Inspector Marina Moffatt, at (705) 564-3133. The plan is due on May 22, 2015, with a compliance date of June 19, 2015.

**Grounds / Motifs :**

1. The licensee has failed to ensure that there is at least one Registered Nurse (RN), who is an employee of the licensee and a member of the regular nursing staff, on duty and present at all times.

Inspector #595 spoke with the DOC who stated that the home does not have an RN on-site at all times. The DOC stated that on days when there is no RN, a Registered Practical Nurse (RPN) would be used as a replacement. The DOC also identified that on the RN schedule it should have a day, evening and night shift scheduled, however there are some shifts that are left blank because there was no RN to work the shift.

Inspector #595 reviewed the RN schedule for February 22 - March 7, 2015 and the following shifts did not have an RN on duty and present in the home:
February 22 - evening and night shift
February 24 - evening shift
February 25 - day shift
February 26 - day shift
February 27 - evening shift
February 28 - day shift
March 1 - day shift
March 2 - day shift
March 4 - day shift
March 5 - day shift
March 7 - day shift (595)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 19, 2015

**Order # / Ordre no :** 003

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

**Linked to Existing Order / Lien vers ordre existant:**
2014_376594_0008, CO #001;
2014_283544_0028, CO #001;

**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 for achieving compliance under s. 19 (1) of the LTCHA. The plan is to include:

(1) What interventions will be implemented to monitor resident #025 to ensure that other residents are protected from abuse.

(2) Strategies to manage resident #025's abusive behaviours, considering psychological, pharmaceutical, behavioural and physical interventions. Resident responses are to be documented.

(3) Actions to be taken by each discipline to respond to the needs of resident #025.

(4) Strategies to protect resident #028 and other residents, especially those who wander, from resident #025.

(5) A process to ensure that all matters as detailed in LTCHA, 2007, c.8, ss. 24 (1), 195 (2) are immediately reported to the Director.

This plan must be faxed, to the attention of LTCH Inspector Marina Moffatt, at (705) 564-3133. The plan is due on May 22, 2015, with a compliance date of June 5, 2015.

**Grounds / Motifs :**

1. During the following inspections, a Compliance Order was issued under s. 19

(1):
- #2014_283544_0028 (compliance date of January 16, 2015);
- #2014_376594_0008 (compliance date of September 17, 2014); and
- #2014_376594_0005 (compliance date of July 25, 2014).

The licensee failed to protect residents from abuse by s#-112.

Inspector reviewed a CI that was submitted to the Director regarding staff-to-resident abuse. The CI alleged that s#-112 was mean to resident #029 and that they had called them a name. Resident #029 had reported this to s#-113 who in turn reported it to s#-104. The staff member, s#-104, did not immediately report this incident to management or the Director.

On March 11, 2015, Inspector #542 interviewed resident #029 about the incident. The resident stated that when s#-112 had assisted them to the shower, they had complained that the water was cold and then s#-112 called them a 'baby'. The resident stated that they didn't feel as though the staff member should have said that, and at the time they thought that maybe they shouldn't have said anything about the shower being cold. The resident also stated that maybe they shouldn't have said anything because they don't want to get anyone in trouble.

Inspector #542 spoke with the Administrator who stated that an investigation had been conducted for this incident and that the file had been sent to the home's Human Resource Director to be finalized. The Administrator stated that they felt that s#-112 would be terminated. At the beginning of the investigation, s#-112 was suspended. The Administrator also stated that s#-104 received a written warning because they did not report the incident of abuse immediately to management.

On March 12, 2015, Inspector #542 spoke with s#-113, who stated that resident #029 informed them that s#-112 always calls them a 'baby'. The resident also reported that the comment by s#-112 upset them. S#-113 spoke with another resident who informed the staff member that s#-112 is not very nice to them. This information was reported to s#-114 at the end of shift on the same day that resident #029 reported it.

Inspector #542 reviewed s#-112's employee file which did not reveal additional incidents of staff-to-resident abuse. It was noted that the staff member received

training on Prevention of Abuse, Neglect, Retaliation and Resident Rights in 2014. They also received training on Gentle Persuasive Approach (GPA). The education file for s#-104 was also reviewed and indicated that the staff member received training on the same during general orientation in 2014.

In the same CI report submitted, it was documented that s#-112 had also been abusive towards another resident #024, by placing their hand over the resident's mouth in an attempt to quiet them down.

Inspector #542 interviewed s#-114 who stated that they had entered resident #024's room where s#-115 was providing care to resident #024. S#-112 entered the room and told the resident to 'sssshhhh' and covered the resident's mouth with their hand. This was witnessed by s#114 who, initially, did not feel that this was abusive and did not report the incident immediately. The staff member explained to inspector that they now understand that it was not appropriate for s#-112 to do that, and that the incident should have been reported immediately. Inspector #542 was informed by the Administrator that s#-114 received a letter of discipline for not reporting the incident of abuse immediately.

Inspector #542 completed a health record review for resident #024 which indicated that the resident had responsive behaviours, was severely impaired for decision making and they required extensive-total assistance by 1-2 staff for Activities of Daily Living (ADL). (542)

2. The licensee has failed to ensure that residents were protected from abuse by resident #025.

On March 6th, 2015, Inspector #542 reviewed a Critical Incident (CI) report that was submitted to the Director for resident-to-resident abuse. The CI revealed that s#-106 had witnessed resident #028 enter resident #025's room and then reported this to s#-107, who entered the room and found resident #025's hand under resident #028's shirt. According to the CI, resident #028 appeared upset and was crying.

Inspector #542 interviewed s#-106 who stated that they witnessed resident #025 standing at the doorway to their room. Resident #025 then started to guide resident #028 into the room by touching resident #028 by the hand. The staff member informed s#-107 who then intervened.

Inspector #542 spoke with s#-107 who stated that after s#-106 informed them of what was witnessed, they proceeded to resident #025's room and found resident #025 to have their hand under resident #028's shirt. The staff member also indicated that resident #028 appeared upset and was crying. The staff member then separated the residents and reported the incident to one of the managers. The staff member stated that resident #025 has been known to take other residents into their room, although the resident typically attempts to do this with staff.

Inspector #542 completed a health care record review for resident #025. The most recent care plan outlined five interventions that staff were to implement when the resident would demonstrate inappropriate behaviours.

On March 11, 2015 Inspector #542 observed resident #025 ambulating beside another female co-resident down a corridor unsupervised. No staff were observed to re-direct the resident away from the female resident.

Inspector #542 spoke with the DOC who stated that resident #025 was easily redirected; that they are not to be put in a group setting; and that they seldom seek out other female residents. The DOC also explained that the resident had a history of touching females in an inappropriate manner.

Inspector #542 reviewed resident #025's progress notes which revealed numerous incidents of inappropriate behaviors towards staff and visitors. In one instance, prior to the submission of this CI, it was documented by s#-108 that resident #025 was inappropriate in a physical manner with another female resident. Inspector spoke with the DOC and Administrator who both stated that they were not aware of this incident. The progress notes did not reveal any specifics about the incident and it was not reported to management or the Director of the MOHLTC. Inspector #542 spoke with s#-108 who stated that they did not witness the incident and it was reported to them by a PSW staff member. S#-108, stated that they were almost 100% sure that resident #025 had physically touched a co-resident's (female) breasts. The staff member could not recall why they did not report the incident or the name of the staff member that reported the incident to them. S#-108 acknowledged that the documentation of the incident should have been much more detailed.

Inspector #542 spoke with s#-109 and s#-110 who worked on the same shift as when this incident occurred. One staff, s#-109, stated that they could not recall

the specific incident on that day as there have been some other incidents where resident #025 has been 'touchy' with family members and staff. The other staff member, s#-110, recalled an incident where resident #025 was inappropriately touching a resident while both residents were sitting in the front lounge, however the staff was unsure if it was the same incident. This staff member was also able to recall another incident where resident #025 had resident #028 in their room and was inappropriately touching them.

Inspector #542 spoke with s#-111 who stated that they were responsible for managing the Responsive Behaviour Committee Meetings, updating care plans, meeting with Behavioural Supports Ontario (BSO), and completing referrals to BSO. The staff member stated that BSO had been involved with resident #025's care for approximately 2-3 months.

Inspector asked s#-111 if there was a copy of BSO report, and the staff member stated that they had not received the written report yet. The staff member informed inspector that the BSO team provided the home with some suggestions verbally on how to minimize resident #025's inappropriate behaviour, including monitoring and distraction. BSO also recommended the use of a specific piece of equipment which would alert the staff when someone enters the room or when resident #025 leaves the room. The staff member stated that the home currently does not have one that resident #025 could use. BSO also suggested other interventions however the home had not implemented them at the time of this inspection.

Inspector #542 reviewed the Responsive Behaviour Meeting Minutes which indicated that there was no improvement in resident #025's behaviour over a five-month period, BSO had been integrated into the resident's care, and different interventions had been discussed.

Inspector #542 was informed by s#-111 that the home completed one-week DOS charting on two separate occasions to document resident #025's behaviours. Inspector #542 reviewed the DOS charting for these two weeks which revealed several gaps in the documentation. During one of the weeks, over a 6-day span there was no documentation between 0730 – 1400 and four days had no documentation from 0730 – 2200.

Inspector reviewed the health care record for resident #028. The most recent RAI-MDS assessment revealed that the resident had short and long-term

memory impairment, was moderately impaired for decision making and exhibited some behavioral symptoms such as wandering. The most current care plan indicated that resident #028 wandered due to a cognitive impairment. In the care plan it identified that resident #028 required one staff to escort them to and from the dining room and activities and assist the resident to locate their room. It was also noted that staff were to redirect resident #028 should they start to disrobe or take items.

On March 12, 2015 at 0951h, Inspector #542 and #575 observed resident #028 to leave the dining room after breakfast. There were no staff walking with the resident. Resident #028 was observed to go into another resident's (male) room, but then wandered back out. Additionally, Inspector #542 had observed other instances throughout the inspection where resident #028 ambulated to and from the dining room without staff supervision. Inspector #542 spoke with s#-111 who stated that BSO staff are not assigned to resident #028 as the resident only wanders and typically does not enter any of the other resident's rooms. (542)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 05, 2015

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

**Order # / Ordre no :** 004

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 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).

**Order / Ordre :**

The licensee shall ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents is complied with.

**Grounds / Motifs :**

1. Inspector #542 reviewed a Critical Incident (CI) report that was submitted to the Director regarding staff-to-resident abuse. Resident #029 reported to s#-113 that s#-112 always calls them a 'baby' and that this upsets them. Another resident informed s#-113 that s#-112 is not very nice to them. This information was reported to s#-104 at the end of shift on February 27, 2015. Inspector #542 spoke with the Administrator who stated that s#-104 did not report this immediately to management, and that the DOC found out the next day as a note was left regarding the incident. The Administrator also stated that s#-104 received a written warning for not reporting the abuse immediately.

In the same CI report, it was identified that another resident #024, was also allegedly abused by s#-112 as witnessed by s#-114. According to the CI, s#-112 had placed their hand over resident #024's mouth trying to 'shhhh' the resident. Inspector spoke with s#-114 who acknowledged that they did not report it immediately. Inspector #542 spoke with the Administrator who stated that s#-114 did not report this incident immediately and that the DOC found out the next day as a note was left regarding the incident. The Administrator also stated that s#-114 received a written warning for not reporting the abuse immediately. ( 542)

2. The licensee has failed to ensure that the home's policy to promote zero

tolerance of abuse and neglect of residents was complied with.

Inspector #542 reviewed the home's policy 'Resident Rights, Care and Services - Abuse - Zero Tolerance - Staff Acknowledgement'. The policy indicated that a staff member of the home who has reasonable grounds to suspect abuse or neglect of a resident must immediately report their suspicion to the most senior administrative personnel on site at the home.

Inspector #542 reviewed resident #025's progress notes which revealed that on an evening shift in February 2015, s#-108 had documented that resident #025 was inappropriate in a physical manner with another female resident. Inspector #542 spoke with the DOC and Administrator who both stated that they were not made aware of this incident. Inspector #542 spoke with s#-108 who stated that they did not witness the incident and it was reported to them by a PSW staff member. The staff member stated that they were almost 100% sure that resident #025 had physically touched the co-resident's breasts. The staff member could not recall why they did not report the incident or the name of the staff member that reported the incident to them. They acknowledged that the documentation of the incident should have been much more detailed. (542)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 05, 2015

**Order # / Ordre no :** 005

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee shall ensure that the staffing plan includes a back-up plan for registered nursing coverage that addresses situations when staff cannot come into work.

**Grounds / Motifs :**

1. During a previous inspection, 2014_283544_0028, a VPC was issued.

The licensee has failed to ensure that the staffing plan included a back-up plan for 24/7 Registered Nurse (RN) coverage that addresses situations when staff cannot come to work.

Inspector #595 requested the home's staffing plan from the Administrator. Upon review of the plan, it was noted that it did not identify a back-up plan for 24/7 RN coverage.

Inspector #595 spoke with the DOC who stated that the home does not have a written back-up staffing plan for RNs. (595)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** May 22, 2015

**Order # / Ordre no :** 006

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

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

**Order / Ordre :**

The licensee shall ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (1) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, and (2) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

**Grounds / Motifs :**

1. During a previous inspection, 2014_283544_0028, a VPC was issued for r. 50 (2) (b) (i) and r. 50 (2) (b) (iv).

The licensee has failed to ensure that resident #003 received a skin assessment by a member of the registered nursing staff within 24 hours of admission.

Inspector #575 spoke with the the DOC (Skin and Wound Care Lead) who stated that upon admission, each resident received a head-to-toe skin assessment that was entered into PointClickCare (PCC) found under the assessments tab. The DOC confirmed that resident #003 did not receive a head-to-toe skin assessment until eight days after admission. The DOC stated that the head-to-toe skin assessment should be completed within 24 hours of admission and that resident #003's assessment was completed late. (575)

2. The licensee has failed to ensure that resident #003 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Inspector #575 reviewed resident #003's health care record. The inspector noted that the resident's RAI-MDS assessment indicated that the resident had three wounds.

Inspector #575 interviewed the DOC (Skin and Wound Lead) regarding resident #003's wounds. The DOC reviewed the resident's progress notes which identified the presence of three wounds. The DOC stated that residents with altered skin integrity receive a 'Wound Assessment and Treatment' assessment which is entered into PCC under the assessment tab. The DOC reviewed the resident's health care record and confirmed to the inspector that the resident did not receive an assessment. (575)

3. Inspector #575 reviewed resident #003's health care record. The inspector noted that the resident's RAI-MDS assessment indicated that the resident had three wounds.

The inspector interviewed the DOC (Skin and Wound Lead) regarding resident #003's wounds. The DOC reviewed the resident's progress notes which identified the presence of three wounds. The DOC stated that staff are required to complete a wound or skin progress note weekly on Wednesdays when a resident exhibits altered skin integrity. The DOC confirmed that there was only wound note for resident #003, and weekly reassessments were not completed.

Inspector #575 reviewed the home's policy titled 'Resident Rights, Care and Services - Skin and Wound Care Program' effective September 16, 2013 which indicated that when a resident has actual alteration in skin integrity registered staff are to complete a wound or skin progress note weekly.
(575)

4. The licensee has failed to ensure that residents #003 and #042 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspector #595 reviewed the health care record for resident #042. It was noted that the resident had one wound. Upon review of the physician's orders, it was identified that there was an order for the resident's wound to be assessed weekly. Inspector #595 spoke with s#-101 and s#-104 who stated that wound assessments are to be completed weekly, using the designated progress note in PCC.

Inspector #595 reviewed the progress notes in PCC which revealed three instances where weekly wound assessments were not completed. Inspector reviewed assessments in PCC and found that there were no completed assessments entered during these three weeks. In one instance, the inspector identified a note that commented on the resident's wound, however an assessment was not completed. (595)

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** May 22, 2015

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

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**Order # / Ordre no :** 007

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

**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 shall prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 53 (4).

The plan must address:

(1) A process to monitor resident #025, and all other residents demonstrating responsive behaviours, in the home.

(2) What actions will be taken in order to manage resident #025's responsive and sexual behaviours, including assessments, reassessments, and interventions. In the event there is no change or improvement, alternative interventions and/or processes are to be identified.

(3) Responsibilities of each discipline in the management of resident #025's responsive behaviours, and any other resident demonstrating responsive behaviours, are to be identified, .

(4) A process to document resident #025's responses to interventions, and any other resident receiving interventions for responsive behaviours.

The plan must be faxed, to the attention to LTCH Inspector Marina Moffatt at (705)-564-3133. The plan is due on May 22, 2015 with a compliance date of June 5, 2015.

**Grounds / Motifs :**

1. During previous inspections, #2013_140158_0037 and #2012_138151_0015, a WN and VPC were issued, respectively, under O. Reg. 79/10, s. 53.

The licensee failed to ensure that actions were taken to respond to the needs of resident #025, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Inspector #542 reviewed a Critical Incident (CI) report that was submitted to the Director for resident-to-resident abuse. The CI revealed that s#-106 had witnessed resident #028 enter resident #025's room and then reported this to s#-107, who entered the room and found resident #025's hand under resident #028's shirt. According to the CI, resident #028 appeared upset and was crying.

Inspector #542 interviewed s#-106 who stated that they witnessed resident #025 standing at the doorway to their room. Resident #025 then started to guide resident #028 into the room by touching resident #028 by the hand. The staff member informed s#-107 who then intervened.

Inspector #542 spoke with s#-107 who stated that after s#-106 informed them of what was witnessed, they proceeded to resident #025's room and found resident #025 to have their hand under resident #028's shirt. The staff member also indicated that resident #028 appeared upset and was crying. The staff member then separated the residents and reported the incident to one of the managers. The staff member stated that resident #025 has been known to take other residents into their room, although typically attempts to do this with staff.

Inspector #542 spoke with the DOC who stated that resident #025 was easily redirected; that they are not to be put in a group setting; and that they seldom seek out other female residents. The DOC also explained that the resident has a history of touching females in an inappropriate manner.

Inspector #542 completed a health care record review for resident #025. The most recent care plan outlined five interventions that staff were to implement when the resident exhibited inappropriate behaviour.

On March 11, 2015 Inspector #542 observed resident #025 ambulating beside another female co-resident down a corridor unsupervised. No staff were observed to re-direct the resident away from the female resident.

Inspector #542 reviewed resident #025's progress notes which revealed numerous incidents of inappropriate and responsive behaviors towards staff and visitors. There was documentation that identified numerous sexually inappropriate and responsive behaviours by resident #025. In one instance, the police were called.

Inspector #542 spoke with s#-109 and s#-110 who worked on the same shift as when the incident between resident #025 and #028 occurred. S#-109 stated that they could not recall the specific incident on that day as there have been some other incidents where resident #025 has been 'touchy' with family members and staff. S#-110 recalled an incident where resident #025 was inappropriately touching another resident while both residents were sitting in the front lounge, however the staff was unsure if it was the same incident. This staff

member was also able to recall another incident where resident #025 had resident #028 in their room and was touching them in a sexual manner.

Inspector #542 spoke with s#-111 who stated that they were responsible for managing the Responsive Behaviour Committee Meetings, updating care plans, meeting with Behavioural Supports Ontario (BSO), and completing referrals to BSO. The staff member stated that BSO had been involved with resident #025's care for approximately 2-3 months. Inspector asked s#-111 if there was a copy of a BSO report, and the staff member stated that they had not received the written report yet. The staff member informed inspector that the BSO team provided the home with some suggestions verbally on how to minimize resident #025's sexually inappropriate behaviour, including monitoring and distraction. BSO also recommended that the home use a specific piece of equipment which would alert the staff when someone enters the room or when resident #025 leaves the room. The staff member stated that the home currently does not have one that resident #025 could use. BSO also suggested other interventions however the home had not implemented them at the time of this inspection.

Inspector #524 reviewed the 'Responsive Behaviour Meeting' minutes as provided by s#-111. It was documented over a five-month span that the resident's responsive behaviours did not change or improve. In one meeting, it was documented that resident #025 was not responding to "no" from staff when exhibiting behaviours. On March 10, 2015 Inspector #542 reviewed resident #025's care plan, which indicated that when the resident exhibits sexual behaviours, staff are to use simple direct commands, such as saying 'no'.

Inspector #542 was informed by s#-111 that the home completed one-week DOS charting on two separate occasions to document resident #025's behaviours. Inspector #542 reviewed the DOS charting for these two weeks which revealed several gaps in the documentation. During one week, over a 6-day span there was no documentation between 0730h – 1400h, and four days had no documentation from 0730h – 2200h. (595)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 05, 2015

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

**Issued on this 7th day of May, 2015**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Marina Moffatt

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