Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 4, 2017	2017_650565_0011	016478-17	Resident Quality Inspection

Licensee/Titulaire de permis

MARKHAVEN, INC.
54 PARKWAY AVENUE MARKHAM ON L3P 2G4

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

MARKHAVEN, INC.
54 PARKWAY AVENUE MARKHAM ON L3P 2G4

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

MATTHEW CHIU (565), FAYLYN KERR-STEWART (664), JOVAIRIA AWAN (648), JOY IERACI (665), SHIHANA RUMZI (604)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 27, 28, 31, August 1, 3, 4, 8, 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 28, 29, and 30, 2017.

During the course of the inspection, the following Critical Incident System (CIS) Intakes were inspected:
- 011570-16 and 004134-17 related to staff to resident neglect
- 033351-16 and 009956-17 related to staff to resident abuse
- 035353-16 related to improper care of a resident
- 004357-17 related to resident injury with unknown cause
- 006809-17 related to resident fall with injury
- 017039-17 related to resident to resident abuse
During the course of the inspection, the following Complaint Intakes were inspected:
- 011115-17, 011973-17, and 018854-16 related to improper care of a resident
- 016307-17, related to resident to resident abuse and improper care of a resident
- 032749-16 related to staff to resident abuse and improper care to resident
- 034447-16 related to reporting and complaints, and resident fall with injury

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Clinical Nurse Manager (CNM), Maintenance Manager (MM), Resident Services Manager (RSM), Human Resources Coordinator (HRC), Support Services Manager (SSM), Registered Dietitian (RD), Physiotherapist (PT), Nursing Supervisors (NS), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), Housekeeping staff (HS), Maintenance staff (MS), Residents, and Family Members.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, staff training records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
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
Training and Orientation
Trust Accounts

During the course of this inspection, Non-Compliances were issued.

- **19 WN(s)**
- **10 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted.

Review of a Critical Incident System (CIS) report revealed on an identified date and time, resident #003 demonstrated identified responsive behaviours and Registered Nurse (RN) #145 and Personal Support Worker (PSW) #146 intervened. During the identified interactions, PSW #146 applied identified physical force towards resident #003. The resident sustained no pain, no bruise, and no injury as a result of the incident.

Review of resident #003's plan of care and Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment revealed the resident had cognitive impairment and demonstrated identified responsive behaviours. The Behavioural Support Services Mobile Support Team (BSS-MST) and identified specialized outside resources were involved with the assessments of the resident's behaviours.

Review of progress notes and Risk Management Incident Report indicated that on the identified date and time, resident #003 demonstrated identified responsive behaviours on the unit. RN #145 and PSW #146 intervened with identified interactions and the resident resisted. RN #145 later brought the resident back to his/her room.

Interviews with RN #145 and PSW #146 indicated resident #003 had demonstrated ongoing identified responsive behaviours towards residents and staff, and had risk of harm to others. The staff members indicated on the identified date and time, the resident was demonstrating the identified responsive behaviours on the unit. Both staff members intervened with identified interactions and the resident resisted and applied identified physical force toward PSW #146. PSW #146 further indicated during the interactions, he/she exchanged identified physical force towards resident #003 for about 15 to 20 seconds for self-defence. Later, RN #145 was able to take the resident back to his/her room. Both Staff members indicated the resident did not expressed pain or sustain any injury as a result of the incident.

Review of the home's surveillance video footage together with the Clinical Nurse Manager (CNM) indicated that at identified time of the identified date when PSW #146 interacted with resident #003, the resident resisted and demonstrated identified responsive behaviours. PSW #146 exchanged with identified physical force towards resident #003 for about 15 seconds. During this interaction, resident #003 posted no immediate risk of harm to the resident himself/herself and other co-residents.

Further interview with the CNM indicated the resident was assessed on the next day and the resident did not express any discomfort or sustain any injury. The CNM stated if he/she handled the same situation, he/she could be calmer to interact with the resident, and the staff member could have different approach to manage the resident's behaviours instead of applying the identified physical force towards the resident.

Interviews with the CNM and the Executive Director (ED) indicated that the resident's dignity should be respected even he/she demonstrated the identified responsive behaviours and the resident should not be held accountable to his/her mentioned behaviours. The CNM and the ED acknowledged that PSW #146 did not respect the resident's dignity applying the identified physical force in reaction to the resident's behaviours. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity is fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

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 has failed to 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.

The Ministry of Health and Long-Term Care (MOHLTC) Director received a complaint on an identified date from the Substitute Decision Maker (SDM) related to resident #006's care. The complainant indicated the resident had numerous falls since his/her admission.

During an interview with the SDM, the SDM indicated he/she was not aware of the fall interventions the home has put in place to manage resident #006's falls.

Record review revealed since admission, resident #006 had nine identified unwitnessed falls in an identified two month period.

Review of resident #006's current written plan of care indicated identified mobility interventions that the resident should receive a specified level of assistance for ambulation and mobility, and the resident is independent with a specified mobility aid for ambulation.

The inspector observed resident #006 ambulating independently throughout the unit without the use of the identified mobility aid during the inspection.

Interviews with Registered Practical Nurse (RPN) #137, #140, PSW #106 and #112 indicated resident #006 ambulates independently and does not use the identified mobility aid. The staff reviewed the written plan of care for resident #006 and acknowledged the written plan of care had conflicting information and did not provide clear directions to staff.

An interview with the CNM, indicated it is the home's expectation that the written plan of care reflects the current care needs of residents. The CNM reviewed the written plan of care of resident #006 and acknowledged the written plan of care had conflicting information regarding resident's mobility status and did not provide clear directions for staff. [s. 6. (1) (c)]

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

Observations and inquiry conducted during an identified shift on an identified date indicated resident #030 had been provided with a specified care and left in bed by PSW #123. Subsequent observations conducted by the inspector indicated resident #030 could not be interviewed due to specified communication and cognitive status.

Record review of resident # 030's clinical records identified he/she had cognitive impairment. Review of resident #030's written plan of care identified he/she required specified staff assistance for the specified care. The written plan of care further identified resident #030 had specified communication status.

Interview with PSW #123 indicated that he/she routinely provided the specified care to three residents during the identified shift as per the home's direction. During observations conducted on the identified date, PSW #123 confirmed resident #030 had been provided with the specified care during his/her shift. Subsequent interview with PSW #123

confirmed that during a specified time period in his/her shift, resident #030 was typically provided with the specified care that supposed to be given to the resident for the following shift. PSW #123 was unable to identify if the preference to the specified care for the resident would be included in the written plan of care. PSW #123 reported resident #030 required specified assistance for the care and was unable to communicate his/her expressed preferences. PSW #123 reported he/she would not consider providing the specified care to the residents and returning them to bed was appropriate during the identified shift.

Interview with PSW #131 and #132 reported residents were expected to receive the specified care according to the time of day. PSW #131 and #132 identified residents were expected to be provided the specified care between an identified time period in the morning.

Interview with PSW #132 identified resident #030 was routinely provided with the specified care prior to his/her usual shift in the morning. PSW #132 confirmed this provision would not be included in the written plan of care, and reported this was done to assist staff in the morning. PSW #132 revealed resident #030 had specified communication status. PSW #132 stated residents were provided with the specified care during the identified shift were in inappropriate for the time of day.

Interview with the CNM identified resident's needs and preferences are typically identified during the admission care plan and annual care plan review with family members thereafter. The CNM reported preferences and consent was to be obtained to be provided with the specified care during the identified shift, and these preferences were to be included in a resident's written plan of care. Staff interviews, observations, and resident #030's written plan of care were reviewed with the CNM. The CNM confirmed it was not appropriate for resident #030 to be provided with the specified care during the identified time period of the identified shift. The CNM identified resident #030 had specified communication status and was unable to demonstrate resident #030 had been assessed for his/her preference to be provided with the specified care during the identified shift. [s. 6. (2)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

The MOHLTC Director received a complaint on an identified date from the SDM related to resident #006's care. The complainant indicated the resident had numerous falls since his/her admission.

Record review revealed since admission, resident #006 had nine identified unwitnessed falls in an identified two month period.

Review of resident #006's Physiotherapist's (PT) post fall assessment notes and current written plan of care indicated identified fall prevention strategies, that being recommended by the PT, were not included in the current written plan of care

The inspector observed resident #006 ambulating independently throughout the unit without the use of the identified mobility aid that being recommended by the above mentioned PT assessment notes.

An interview with RPN #140 indicated recommendations from the PT are to be reviewed and assessed by the registered staff and discussed with the CNM if required. The plan of care will be updated to reflect the PT recommendations or a progress note will be completed if the recommendations are not implemented.

An interview with the CNM indicated it is the home's expectation for the recommendations from the PT be addressed by the registered staff. If the recommendations are implemented, the plan of care is updated, or a progress note is completed when the recommendations are not implemented. The CNM acknowledged the PT's fall prevention recommendations for resident #006 noted above was not addressed in the resident's plan of care. [s. 6. (4) (a)]

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

During stage one of the Resident Quality Inspection (RQI), resident #001 was identified to have a low Body Mass Index (BMI).

Review of resident #001's RAI-MDS assessment identified resident #001 had identified significant weight loss during two identified period possibly related to specified nutritional and dietary status.

At the time of the inspection, resident #001's clinical records identified he/she had an

identified BMI.

Review of resident #001's weight history indicated identified significant weight loss trends during an identified two month period.

Review of resident #001's progress notes identified the Registered Dietitian (RD) assessed the resident during the above mentioned two month period for the identified significant weight loss.

Review of resident #001's written plan of care identified the resident to be at specified nutrition risk related to specified dietary status and at an identified per cent of the resident Ideal Body Weight (IBW) range. The written plan of care included identified interventions and refer to the RD under a specified resident intake.

Interview with PSW #106 revealed staff are expected to report to the registered staff if a change in a resident's food and fluid intake is noticed. PSW #106 indicated he/she was aware of resident #001's ongoing weight loss and variable intake at meal. PSW #106 demonstrated interventions to manage resident #001's nutrition risk included that a referral would be sent to the RD under the specified resident intake.

Interview with RPN #102 revealed staff are expected to monitor resident food and fluid intake through flowsheets and Point Of Care (POC) documentation. RPN #102 reported the night shift PSWs review the flowsheets and identify intake patterns and report to the night's registered staff which would then complete a referral to the RD under the Dietary Referral Note in Point Click Care (PCC).

RPN #102 identified interventions in resident #001's written plan of care that a referral was to be made to the RD when the specified resident intake had occurred.

Review of resident #001's food and fluid intake flow sheets indicated during an identified period, the specified resident intake for referring to the RD had occurred.

Review of resident #001's clinical records with RPN #102 did not identify that a Dietary Referral Note was sent to the RD for these time periods identified above. RPN #102 confirmed that a referral to the RD had not been completed for the identified periods listed above when the specified resident intake occurred.

Interview with the RD indicated the expectation of the home is for staff to follow the

written plan of care related. The RD identified that registered staff communicated nutrition referrals through the Dietary Referral Note in PCC.

Review of resident #001's clinical records and food and fluid intake (as noted above) with the RD and the RD did not identify a Dietary Referral Note for these time periods had been made as a referral when the specified resident intake occurred. The RD stated the homes expectation to send a referral was not met and the protocol was not followed.

Interview with the homes CNM indicated staff are expected to follow interventions outlined in a resident's written plan of care. The homes CNM confirmed the RD did not receive a referral for resident #001 despite the specified resident intake occurred. The CNM confirmed the care set out in resident #001's care plan was not followed. [s. 6. (7)]

5. Review of a CIS report revealed on an identified date and time, staff heard resident #011 calling out and found the resident sitting upright on floor in his/her room. The resident was sent to the hospital and subsequently diagnosed with an identified significant injury on the same day.

Review of resident #011's risk management fall incident notes and progress notes indicated on the identified date and time, RPN #102 found resident #011 in an identified room, sitting on the floor in pain. Identified actions were taken by RPN #102 and he/she left the resident. When RPN #102 returned to resident #011's room, the RPN found the resident sitting on the floor. The resident was further assessed and then sent to the hospital at an identified time.

Review of resident #011's plan of care revealed the resident had both physical and cognitive impairments. The falls prevention plan of care indicated the resident was at risk for falls. One of the falls prevention interventions indicated that an identified device should put in place for the resident when he/she was in bed.

Interview with the PT indicated that he/she assessed the resident on an identified date and recommended the use of the identified device because the resident might demonstrate an identified behaviour and it was unsafe. The PT documented and communicated the recommendation with nursing staff.

Interview with PSW #112 indicated at the time of this incident, one of the contributing factors for resident #011's risk for falls was he/she was unsteady. The identified device was implemented to manage the resident's above mentioned behaviour. The staff

member did not recall when the identified device was first implemented for the resident.

Interview with RPN #102 indicated on the identified date, the staff found resident #011 lying on the floor in an identified room, and the resident was expressing pain. After assessing resident #011, the resident was transferred back to bed in his/her room. RPN #102 left the resident for identified actions. When RPN #102 returned to resident #011's room, he/she found the resident fell again. The staff member confirmed the identified device was not being applied when the resident was in bed, and it should have been.

Interview with the CNM confirmed that the use of the identified device was first initiated in the plan of care on an identified date, and therefore when the above mentioned incident happened, the identified device should be applied for the resident when he/she was in bed, but it was not. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- there 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,
- the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident,
- the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other,
- the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During stage one of the RQI, resident observation revealed that in room #1022's bathroom, the grab bar to the left side of the toilet was loose.

On August 4, 2017, in room #1022's bathroom, the inspector observed that on each side of the toilet, a grab bar was mounted on the wall by screws. On the left grab bar, two of the screws were not tight and therefore the grab bar was not secured on the wall and was loose.

Subsequent observations and interviews with PSW #106, RPN #102, and Maintenance Staff (MS) #107 confirmed the above mentioned grab bar was loose and stated they were not aware of it. The staff members further indicated that they don't know how long it had been loose. The home has a computer program for submitting maintenance request and they were not aware of any request was being submitted to the maintenance department for repairing the grab bar. The staff members confirmed the screws should be tightened and the grab bar should be mounted securely on the wall.

Interview with the Maintenance Manager confirmed the grab bar should be securely mounted on the wall and be maintained in a good state of repair, but it was not. [s. 15. (2) (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 the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

During stage one of the RQI, observations conducted in resident #029's room on July 28, 2017, identified the resident's bedroom call bell did not activate when call bell button was pressed. The observation was immediately repeated in the presence of PSW #131 and confirmed the call bell in residents #029's bedroom could not be activated to alert staff to the home's communication response system. PSW #131 proceeded to inform maintenance staff and registered staff on the unit of the call bell for repair.

Record review of resident #029's written plan of care identified he/she was at risk of falls related to the identified health status.

Interview with PSW #131 identified that resident #029 was capable of using the call bell in his/her bedroom. PSW #131 confirmed resident #029's bedroom call bell was not functional, and posed a risk if the call bell was not functional as the resident would be unable to alert staff.

Interview with the CNM confirmed resident #029 was capable of using his/her call bell in the bedroom to alert staff. The CNM confirmed the non-functional call bell would put resident #029 at risk as he/she was capable of using the call and was also noted to have a risk of falls.

The home failed to have a resident-staff communication response system that can be easily accessed and used by residents at all times. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #5: 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 anyone and free from neglect by the licensee or staff in the home.

The MOHLTC received a CIS report on an identified date identifying an allegation of staff to resident abuse. The CIS identified PSW #158 witnessed PSW #161 did not provide a specified care to resident #032 when requested by the resident, during toileting. Resident #032 requested the specified care and PSW #161 allegedly did not provide resident with the specified care and stated to the resident that he/she would provide the specified care when toileting was completed.

Record review of resident #032's clinical records indicated he/she had an identified diagnosis. Review of resident #032's written care plan in place at the time of the alleged incident the resident had an identified health condition and was dependent on the specified care. The written plan of care identified that the resident was to be offered with the specified care and directed staff to ensure the specified care is used at all times. Resident #032 had been discharged on an identified date and could not be interviewed or contacted at the time of the inspection.

Interview with PSW #158 revealed at the time of the incident, resident #032 required identified toileting assistance. PSW #158 revealed resident #032 required the specified care and was able to communicate with staff when to receive the specified care. PSW #158 stated at the time of the incident, he/she was responding to resident #032's call bell for toileting. PSW #158 arrived to resident #032's room where PSW #161 was already present and proceeded to assist PSW #161 for toileting resident #032. PSW #158 reported to the inspector that during the identified interaction, PSW #161 verbally communicated to resident #032 in an identified manner and did not provide the specified care to resident #032. PSW #158 acknowledged PSW #161 had abused and neglected

to provide the specified care upon request to resident #032.

PSW #161 was unavailable for an interview during the inspection.

Interview with RN #162, identified by the CNM as the staff on shift on resident #032's home area at the time of the incident, identified he/she was could not recall the alleged incident.

Review of resident #032's clinical records did not identify documentation of the alleged incident during the identified time frame.

Review of the homes documentation identified PSW #161 had a history of progressive discipline for identified areas. The home determined resident #032 had been neglected by PSW #161 as a result of the homes investigation of this identified incident.

Interview with the CNM confirmed the homes investigation determined resident #032 had neglected by PSW #161.

Interview with the Human Resources Coordinator (HRC) and the ED confirmed PSW #161 had a history of progressive discipline in identified areas.

The licensee failed to ensure resident #032 was protected from abuse and neglect by PSW #161 during the provision of continence care as witnessed by PSW #158. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's nutrition status, including weight and any risks related to nutrition care.

During stage one of the RQI, resident #001 was identified to have a low BMI.

Review of resident #001's medical history identified he/she had an identified diagnosis.

Review of resident #001's RAI-MDS assessment identified resident #001 had identified significant weight change during two identified period possibly related to specified nutritional and dietary status.

At the time of the inspection, resident #001's clinical records identified he/she had an identified BMI.

Review of resident #001's weight history indicated identified significant weight change trends during an identified six month period.

A cumulative review of the total weight change during an identified nine month period indicated resident #001 sustained an identified significant weight change.

Review of resident #001's progress notes identified the RD assessed the resident on seven identified dates during an identified seven month period.

Review of resident #001's written plan of care identified the resident to be at specified nutrition risk related to specified dietary status and at an identified per cent of the resident IBW range. The written plan of care identified that resident #001's goal was to remain within a specified IBW range and meet calculated nutrition requirements.

Observations conducted of resident #001 during identified meal services identified he/she would demonstrate identified responsive behaviours during meal times. Staff were noted to offer encouragement to resident #001 during meals to promote intake.

Interview with PSW #106 revealed he/she was aware of resident #001's ongoing weight change and variable intake at meals. PSW #106 identified resident #001's ability to eat at meals was affected due to the progression of his/her identified diagnosis and responsive behaviours during meal times.

Interview with PSW #112 identified resident #001 often demonstrated the identified responsive behaviours during meal services and required encouragement to accept meals.

Interview with RPN #102 revealed staff are expected to monitor resident food and fluid intake through flowsheets and POC documentation. RPN #102 reported the night shift PSWs should review the flowsheets and identify intake patterns. The night shift PSWs are expected to report variable intake patterns identified to the night shift registered staff who would then complete a referral to the RD. RPN #102 identified resident #001's identified diagnosis and weight change put him/her at identified nutrition risk along with his/her identified responsive behaviours in the dining room during meal time. RPN #102 indicated that resident's identified diagnosis would be expected to be included as a nutrition related risk factor in the resident's written plan of care.

Interview with the RD identified that resident care plans include identified factors which would contribute to a resident's nutrition risk. The RD identified that resident #001 had unpredictable food intake due to the identified responsive behaviours in the dining room at meal times, significant ongoing weight change, and the identified diagnosis. Review of resident #001's written plan of care related to nutrition with the RD identified that it did not include the identified nutrition risk factors for resident #001. During the review of

resident #001's weight change during the RD interview, he/she indicated preventing further weight change would be the appropriate goal for a resident with significant ongoing weight change over the period reviewed by the inspector. RD confirmed the residents' plan of care did not include the identified factors which contributed to resident #001's identified nutrition risk and that the goal of the nutrition care plan did not address the ongoing weight change.

Interview with the CNM identified a written plan of care of a resident is reviewed and revised quarterly and at any other time when a resident is identified with a significant change would be expected to include all identified risk factors and appropriate goals based on the resident's change. The CNM acknowledged resident #001's written plan of care did not identify the residents nutritional status including all risks related to nutrition care upon reviewing the nutrition related focus and goals and accompanying staff reports related to resident #001 with the inspector. [s. 26. (3) 13.]

2. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's skin condition, including altered skin integrity and foot conditions.

During stage one of the RQI, resident #001 was revealed to have an identified skin condition on an identified date.

Observations conducted on another identified date indicated resident #001 had the identified skin condition.

Review of resident #001's written plan of care in place at the time of the inspection did not identify a focus related to skin care. No skin care assessments or related documentation to the observed identified skin condition for resident #001 was identified during the record review.

Interviews with PSW #110 and #112 revealed staff were expected to document changes in skin integrity, including the identified skin condition in POC for residents. PSW #110 and #112 identified they were aware of resident #001's identified skin condition and that the resident was prone to have the identified skin condition.

Interview with RPN #102 revealed that PSW staff were expected to alert registered staff to residents with changes in skin integrity including the identified skin condition through POC documentation. RPN #102 identified written plans of care would include skin related

risk for residents. RPN #102 reported resident #001 was prone to have the identified skin condition. Upon review of resident #001's written plan of care, RPN #102 confirmed resident #001's skin care risk was not captured in resident #001's written plan of care prior to the inspection. RPN #102 was unable to demonstrate the plan of care was based on an interdisciplinary assessment with respect to resident #001's skin condition.

Interview with the CNM identified a resident's written plan of care would include interventions related to skin care management for residents with a known history of skin impairment including fragile skin and the identified skin condition. Review of observations during stage 1, staff interviews, and clinical records related to resident #001, during the interview with the CNM identified resident #001's written plan of care did not demonstrate it was based on an interdisciplinary assessment with respect to resident #001's skin condition. [s. 26. (3) 15.]

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

Observations and inquiry conducted during an identified shift on an identified date indicated resident #031 had been provided with a specified care and left in bed by PSW #123. Subsequent observations conducted by the inspector indicated resident #031 could not be interviewed due to specified communication and cognitive status.

Record review of resident # 031's clinical records identified he/she had cognitive impairment. Review of resident #031's written plan of care identified he/she required specified staff assistance for the specified care. The written plan of care further identified resident #031 had specified communication status.

Interview with PSW #123 indicated that he/she routinely provided the specified care to three residents during the identified shift as per the home's direction. During observations conducted on the identified date, PSW #123 confirmed resident #031 had been provided with the specified care during his/her shift. Subsequent interview with PSW #123 confirmed that during a specified time period in his/her shift, resident #031 was typically provided with the specified care that supposed to be given to the resident for the following shift. PSW #123 was unable to identify if the preference to the specified care for the resident would be included in the written plan of care. PSW #123 reported resident #031 required specified assistance for the care and was unable to communicate his/her expressed preferences. PSW #123 reported he/she would not consider providing the specified care to the residents and returning them to bed was appropriate during the

identified shift.

Interview with PSW #131 and #132 reported residents were expected to receive the specified care according to the time of day. PSW #131 and #132 identified residents were expected to be provided the specified care between an identified time period in the morning.

Interview with PSW #132 identified resident #030 was routinely provided with the specified care prior to his/her usual shift in the morning. PSW #132 confirmed this provision would not be included in the written plan of care, and reported this was done to assist staff in the morning. PSW #132 revealed resident #030 had specified communication status. PSW #132 stated residents were provided with the specified care during the identified shift were inappropriate for the time of day.

Interview with the CNM identified resident's needs and preferences are typically identified during the admission care plan and annual care plan review with family members thereafter. The CNM reported preferences and consent was to be obtained to be provide with the specified care during the identified shift, and these preferences were to be included in a resident's written plan of care. Staff interviews, observations, and resident #031's written plan of care were reviewed with the CNM. The CNM confirmed it was not appropriate for resident #031 sleep pattern to be provided with the specified care during the identified time period of the identified shift. The CNM identified resident #031 had specified communication status and was unable to demonstrate resident #031 had been assessed for his/her preference to be provided with the specified care during the identified shift. [s. 26. (3) 21.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care must be based on, at minimum, an interdisciplinary assessment of the following with respect to the resident:
- Nutrition status, including weight and any risks related to nutrition care,
- Skin condition, including altered skin integrity and foot conditions,
- Sleep patterns and preferences, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

The MOHTLC received a CIS report on an identified date identifying that resident #035 was transferred on an unidentified date, independently without a lift by staff. Resident #035 was discovered by a PSW with an identified injury.

Record review of resident #035's progress notes revealed an identified assessment note dated on the identified date. The note identified resident #035 had the identified injury.

Interview with PSW #133 identified he/she was expected to provide resident transfers using a mechanical lift with two staff assistance. PSW #133 identified two staff were required to operate mechanical lifts in order to safely transfer residents. Upon review of the incident related to resident #035, PSW #133 confirmed he/she had transferred resident #035 independently without co-staff assistance using an identified mechanical lift, and acknowledged it was an unsafe transfer. PSW #133 did not identify injury on resident #035 following this transfer.

Interview with PSW #135 revealed resident #035 required specified care and was a two person using the identified mechanical lift for transfer at the time of the incident. PSW #135 reported he/she observed the identified injury on resident #035 and had reported it to registered staff at the time of discovery.

Interview with RPN #156 identified resident #035 required specified assistance for care and was a two staff using the identified mechanical lift for transfer. RPN #156 identified it would be unsafe for resident #035 to be transferred by one staff using a mechanical lift. RPN #156 indicated PSW #135 reported the identified injury on resident #035 on the evening of the identified date.

Interview with the CNM identified staff providing care to residents in the home were expected to follow interventions as directed in the written plan of care. The CNM reported residents requiring the identified mechanical lift transfers required two staff to safely complete the transfer and to do so otherwise would put the resident at safety risk. The CNM confirmed PSW #133 had reported to the home that resident #035 was unsafely transferred in the identified mechanical lift without two staff assistance. The home's investigation was unable to determine the cause of the identified injury on resident #035. [s. 36.]

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 use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Review of a CIS report revealed on an identified date and time, resident #003 demonstrated identified responsive behaviours and RN #145 and PSW #146 intervened. During the identified interactions, PSW #146 applied identified physical force towards resident #003. The resident sustained no pain, no bruise, and no injury as a result of the incident.

Review of resident #003's plan of care and RAI-MDS assessment revealed the resident had cognitive impairment and demonstrated identified responsive behaviours. The

resident's behaviours were not easily altered.

Review of resident #003's progress notes and behaviour tracking flowsheets indicated since the resident admitted, the resident had demonstrated ongoing identified responsive behaviours towards residents and staff, and was resistive to care. The BSS-MST and identified outside specialized resources were involved with the assessments of the resident's behaviours.

Review of resident #003's plan of care indicated BSS-MST had recommended behavioural management for the resident's resistance to care on an identified date. Further review of the plan of care indicated strategies were implemented in relation to resident's certain identified responsive behaviours. The plan of care did not identify any interventions to minimize the risk of altercations and potentially harmful interactions between and among residents until after the above mentioned incident.

Interviews with PSW #106 and #144 indicated that the resident had ongoing identified responsive behaviours towards both residents and staff since admission. The staff members indicated identified behavioural triggers for the resident's responsive behaviours. The staff members did not recall any interventions were implemented to minimize the risk of altercation. PSW #144 further stated that the BSS-MST's recommendation was focus on the resident's refusing specified care, and PSW #106 indicated he/she was scared about resident #003's identified responsive behaviours.

Interview with RN #145 indicated resident #003 had demonstrated identified responsive behaviours towards residents and staff, and had risk of harm to others. The staff member recalled there was a co-resident who would trigger altercations with resident #003 and the home had implemented identified action for this co-resident. The staff member did not recall any interventions were being implemented for resident #003 to minimize the risk of altercations and potentially harmful interactions between resident #003 and other residents and staff.

Interview with The CNM indicated since resident #003 admitted to the home, the resident had demonstrated ongoing identified responsive behaviours towards co-residents and staff members. The resident had been seen by identified outside specialized resources and BSS-MST for medication and interventions managing his/her behaviours. Upon reviewing resident #003's plan of care, the CNM confirmed that no interventions were identified and implemented for staff to minimize the resident's risk of altercations and potentially harmful interactions between and among residents at the time of the above

mentioned incident. [s. 55. (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 procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal.

The inspector conducted a breakfast meal service observation on one North on August 9, 2017, as resident #041's SDM indicated in an interview that the dining room is very loud and residents are rushed during the meals.

During the breakfast meal observation the inspector observed 16 residents in the dining room and each resident received cream of wheat followed by two slices of toast with jam, a peeled and sliced banana, and a yogurt as their main meal. The inspector observed two residents had received hardboiled eggs as well.

The posted menu located outside the one North dining room indicated week one, Wednesday, cream of wheat, cheddar cheese, whole wheat toast, and stewed rhubarb. The inspector noted the planned menu items were not offered.

An interview with PSW #116 indicated he/she was serving in one North dining room for breakfast and provided residents with cream of wheat then two slices of toast with jam, a peeled and sliced banana, and a yogurt as their main meal and some residents had received boiled eggs as it was their regular breakfast request. The PSW stated the posted meal is not what he/she served and confirmed that he/she was not provided with cheddar cheese or stewed rhubarb by the Dietary Aide (DA) as a choice for the residents.

An interview with the DA #113, stated the posted menu was not served as the kitchen did not make the menu item.

An interview with the Support Services Manager (SSM) indicated he/she manages the Dietary department and creates the daily menu. The SSM acknowledged that the posted menu items were not offered at breakfast on one North as the cheddar cheese was not served by the DA and the stewed rhubarb was not available. [s. 71. (4)]

2. The inspector conducted a breakfast meal service observation on August 22, 2017, as resident #006 was triggered from stage one for no plan-low BMI.

The posted menu located outside the one North dining room indicated week three, Tuesday: oatmeal, poached egg, whole wheat toast and stewed prunes.

During the breakfast meal observation, the inspector observed hard boiled eggs were served instead of poached eggs to 15 residents in the dining room. The inspector observed the planned menu item of poached eggs was not offered or available in the servery.

An interview with PSW #116 indicated DA #113 told him/her to offer the residents the hard boiled eggs. PSW #116 stated he/she did not serve the poached eggs according to the posted menu and was not provided the poached eggs by the dietary aide to serve.

An interview with DA #113 indicated the posted menu item of poached eggs were not served as the cook only provided hard boiled eggs instead of poached eggs.

An interview with the SSM indicated he/she was notified by the cook after the breakfast meal service that the posted menu item of poached eggs was not offered and not available at breakfast in one North. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the planned menu items are offered and available at each meal, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all menu substitutions were communicated to residents and staff.

The inspector conducted a breakfast meal service observation on one North on August 9, 2017, as resident #041's SDM in an interview indicated the dining room is very loud and residents are rushed during the meals.

During the breakfast meal observation the inspector observed 16 residents in the dining room and each resident received cream of wheat followed by two slices of toast with jam, a peeled and sliced banana, and a yogurt as their main meal. The inspector observed two resident had received hardboiled eggs as well.

The posted menu located outside the one North dining room indicated week one, Wednesday, cream of wheat, cheddar cheese, whole wheat toast, and stewed rhubarb. The inspector noted the planned menu items were not offered or available at the servery.

An interview with PSW #116 indicated he/she was serving in one North dining room for breakfast and provided residents with cream of wheat then two slices of toast with jam, a peeled and sliced banana, and a yogurt as their main meal and some resident had

received boiled eggs as it's their regular breakfast request. The PSW stated the posted meal is not what he/she served and confirmed that he/she was not aware of the menu substitutions as he/she was not informed by the DA serving the meal and it was not posted.

An interview with the DA # 113, stated if there is a menu change or substitution the changes are posted on the posted menu. The DA indicated the posted menu was not served as the stewed rhubarb was not available and the menu was changed to banana and yogurt. The DA stated she did not communicate the menu changes or substitutions to the residents or staff and the menu was not changed.

An interview with the SSM indicated he/she manages the Dietary department and creates the daily menu. The SSM acknowledged that the DA did not communicate the menu substitutions to residents or staff. [s. 72. (2) (f)]

2. The inspector conducted a breakfast meal service observation on August 22, 2017, as resident #006 was triggered from stage one for no plan-low BMI.

The posted menu located outside the one North dining room indicated week three, Tuesday: oatmeal, poached egg, whole wheat toast and stewed prunes.

During the breakfast meal observation, the inspector observed hard boiled eggs was served instead of poached eggs to 15 residents in the dining room. The inspector observed the planned menu item of poached eggs was not offered or available in the servery.

An interview with PSW #116 indicated DA #113 told him/her to offer the residents with hard boiled eggs. PSW #116 stated he/she did not serve the poached eggs according to the posted menu and acknowledged he/she was not aware of the menu substitution as he/she was not informed by DA #113 and the substitution was not posted.

An interview with RPN #140, who was the unit nurse, acknowledged that the dietary aide did not communicate to him/her of the menu substitution for the breakfast meal service.

An interview with DA #113 indicated the posted menu item of poached eggs were not served as the cook only provided hard boiled eggs instead of poached eggs. DA #113 acknowledged that he/she did not communicate to the unit staff and residents of the menu substitution and the posted menu was not changed.

An interview with the SSM indicated he/she was notified by the cook after the breakfast meal service that the posted menu item of poached eggs was not offered and not available at breakfast in one North. The SSM acknowledged that the dietary aide did not communicate the menu substitution to residents and staff. [s. 72. (2) (f)]

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 all menu substitutions are communicated to residents and staff, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 4. Mission statement

Specifically failed to comply with the following:

s. 4. (4) At least once every five years after a mission statement is developed, the licensee shall consult with the Residents' Council and the Family Council, if any, as to whether revisions are required, and shall invite the staff of the long-term care home and volunteers to participate. 2007, c. 8, s. 4. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once every five years after the mission statement has been developed, the licensee shall consult with the Family Council, if any, as to whether revisions are required.

Interview with an identified member of the Family Council (FC) indicated that his/her loved one has been at the home for an identified number of years and does not recall the home reviewing the home's Mission statement with the Family Council (FC).

An interview with the home's Resident Services Coordinator (RSC), indicated he/she is the assistant appointed by the home to the FC and has been in the home for 13 years. The RSC stated he/she did not recall the home consulting the FC related to the home's mission statement and any revisions being carried out. The RSC also indicated he/she reviewed the FC minutes for the past five years and the minutes show evidence of the home only communicating to the Residents' Council the home's mission statement and not the FC.

An interview with the ED indicated he/she has been at the home since April 2016, and has not reviewed the home's mission statement with the FC and is unable to show evidence if the RSC has no minutes to show the home did so. The ED indicated he/she will have to carry out a review with the FC of the home's mission statement. [s. 4. (4)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or 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, was complied with.

a. According to O.Reg.79/10, s. 136 (2) (1), That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

The home follows Medisystem Pharmacy's Policies and Procedures for Medication Management. Medisystem Pharmacy's policy titled, "Disposal of Discontinued/Expired drugs, Narcotics and Controlled Substances" last reviewed date of January 17, 2017, revealed that discontinued narcotics and controlled substances are to be removed from the medication cart and the individual Narcotic and Controlled Substance Administration Record signed and dated prior to being placed into the double locked centralized storage are within the home.

During the mandatory medication observation for storage of narcotics and controlled substances conducted on an identified home area on an identified date and time found discontinued narcotics for resident #067 in the unit's medication cart's narcotic box. The narcotics were as follows:
- 13 pills of an identified drug which was discontinued on an identified date,
- 18 pills of another identified drug which was discontinued on the same identified date.

An interview with the RN Supervisor #118, stated discontinued narcotics are to be removed from the medication cart and taken to one north medication room where the narcotics and controlled substances is to be deposited in the narcotics and controlled substance lock bin until drug destruction is done with the Director of Care (DOC) and the pharmacist. The RN Supervisor stated the discontinued narcotics should immediately be deposited in the bin right away once the medication is discontinued as per the home's policy. The RN Supervisor indicated resident #067's identified drug was removed from the unit's medication cart after it was brought to the attention of the inspector. The RN Supervisor further stated, he/she was just made aware of another discontinued identified drug and will also be removed from the narcotic box in the medication cart.

Interview with the DOC indicated that it is the home's expectation for discontinued narcotics be removed from the home area's medication cart and deposited in the home's locked bin for narcotics and controlled substances located in one North's medication room. The DOC stated resident #067's identified discontinued drug should have been

deposited in the locked bin after the last dose on the identified date for destruction. The DOC acknowledged the staff did not follow the home's expectation that drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

b. The home follows Medisystem Pharmacy's Policies and Procedures for Medication Management. Medisystem Pharmacy's policy titled, "Narcotic and Controlled Substances Administration Record", last reviewed date of January 17, 2017, revealed under procedure number four: all entries must be made at the time the drug is removed from the container; and number seven: a count of all narcotics can be made on the Narcotic and Controlled substance Administration Record. A check of the balance-on-hand must be done by two nurses or care providers as per facility policy at the time of every shift change or as per facility policy.

The home's policy titled, "Narcotics/Controlled Drugs", reviewed/revised date of February 2015, stated under procedure number three: the registered staff on duty and the registered staff coming on duty will jointly count narcotics at all shift changes.

During the mandatory medication observations on two identified dates, the inspector found the following:
- On the first identified date, at 1200 hours on an identified home area, RPN #102 signed for resident #031's 0800 hours dose of an identified drug at 1200 hours.
- On the first identified date, at 1430 hours on an identified home area, RPN #102 initiated the shift exchange count before 1500 hours without the incoming registered staff. Review of the individual narcotic administration records found RPN #102 initiated the shift exchange count on five of the six individual narcotic sheets for residents #031, #041, #074, and #077.
- On the second identified date, at 1030 hours on an identified home area, RPN #104 did not sign resident #067's 0900 hours dose of an identified drug until 1030 hours. RPN #104 indicated he/she administered the dose at 0945 hours to the resident.
- On the second identified date, at 1100 hours on an identified home area, resident #068's 0600 hours dose of a half tablet of an identified drug was not signed by the night nurse on the narcotic and controlled substance administration record. Review of the narcotic and controlled drug administration record for resident #068's identified drug revealed the shift exchange count was completed at 0700 hours but the count was incorrect. There were three tablets of the identified drug in the narcotic sleeve, but the count was documented as four tablets.

- On the second identified date, at 1100 hours on an identified home area, resident #069's, identified narcotic drug and controlled drug administration record revealed the 0700 hours shift exchange count to be incorrect. The narcotic sleeve had four tablets, but the shift count documented three tablets of the identified drug. RPN #101 indicated that he/she had put the wrong amount on the resident #069's count sheet.

Interviews with RPN #101, #102, and #104 indicated it is the home's expectation for narcotic counts to be done by two registered staff at shift change to ensure accuracy and catch discrepancies and to record and sign off on the resident's narcotic and controlled drug administration record immediately after administering a narcotic dose to a resident. The RPNs acknowledged they did not follow home's expectation regarding narcotic administration and shift exchange narcotic counts.

An interview with the DOC indicated it is the home's policy for narcotic and controlled substance counts are completed by two registered staff at shift change to ensure the counts are correct and to catch any discrepancies. The DOC acknowledged the staff did not follow the home's expectation as shift exchange counts was initiated by RPN #102 at 1430 hours and the narcotic counts were not accurate for residents #068 and #069. The DOC stated it is the home's expectation for the registered staff to sign for the narcotic on the resident's narcotic and controlled drug administration record immediately after administration of the narcotic. The DOC acknowledged the staff did not follow the home's expectation to immediately record the administration of the narcotic on the resident's narcotic and controlled drug administration record. [s. 8. (1) (b)]

2. The MOHLTC ACTIONline received a call on an identified date from the SDM related to resident #042's care.

During an interview with the SDM on an identified date, he/she indicated to the inspector that he/she was unsure of what care was being provided to resident #042 and if the specified care was being carried out.

The home follows MediSystem's polices, policy "Digital MAR/TAR and Electronic Medication Administration System", with a last reviewed date of January 17, 2017, under signing on the digiMAR and digiTAR sheets number two directs staff to ensure that whenever a medication is administered (or treatment) the nurse or care provided must initial in the box opposite that medication (or treatment) for the date and time given with the digital pen.

A review of resident #042 Treatment Administration Record (TAR) record for three identified consecutive months indicated the following:
- Physician for an identified date indicated part of the order related to perform the specified care every shift.

On the following dates and shifts signatures were missing on the TAR sheet:
- Day shift: three identified dates,
- Evening shift: 13 identified dates,
- Night shift: one identified month and nine other identified dates in another month.

An identified Physician order directed staff to provide a specified care. On the following dates in an identified month, there were missing signatures:
- Day shift: three identified dates,
- Evening shift: 11 identified dates,
- Night shift: four identified dates.

Interviews with RPN #150 and #151 indicated it was the home's expectation and policy that the staff sign of the MAR sheets once care and treatment was provided. The RPN's indicated if there were missing signatures he/she would assume reviewing the MARs that the care was not provide to resident #042.

Interview with the CNM stated it was the home's policy that registered staff administering medication and treatments sign off the TARs once treatment is provide. The CNM reviewed the TARs for the two identified months for resident #042 and stated the dates indicated above where missing the signatures and it would be interpreted as care not being provided to the resident. The CNM acknowledged that the registered staff did not follow the home's policy to sign off care once provided. [s. 8. (1) (b)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in risk of harm and unlawful conduct that resulted in risk of harm to a resident, immediately report the suspicion and the information upon which it was based to the director.

The MOHLTC received a CIS report on an identified date identifying an allegation of staff to resident abuse related to resident #032. The CIS identified PSW #158 witnessed PSW #161 neglected to provide a specified care to resident #032 when requested by the resident, during toileting. Resident #032 requested the specified care and PSW #161 allegedly did not provide resident with the specified care and stated to the resident that he/she would provide the specified care when toileting was completed.

Record review of the homes investigation identified PSW #158 had been interviewed by the home on an identified date by the CNM.

Interview with the ED confirmed the CNM was aware of the allegation on the same date when PSW #158 was interviewed. The ED confirmed the CIS report was made on an identified date in April 2016.

The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that

resulted in harm or risk of harm had occurred, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

2. The MOHLTC received a CIS report on an identified date revealing a resident to resident abuse. The CIS report indicated 18 days before the report was submitted, an identified interaction between resident #006 and #070 had happened. During that time, RPN #105 observed resident #070 demonstrating an identified action towards resident #006.

Interview with RPN #105 confirmed he/she had witnessed resident #070 demonstrating the identified action towards resident #006 on an identified date, which is 18 days before the CIS report submission date.

Record review revealed resident #006 sustained identified injuries from the incident.

Interview with the ED indicated he/she was aware of the incident on the day of occurrence. The ED acknowledged the CIS report was not reported immediately to the MOHLTC Director and the CIS report was submitted 18 days after the day of the incident. [s. 24. (1)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition care and hydration programs included a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

The MOHLTC received a complaint related to resident #028. The complainant identified concern related to resident #028 regarding an identified weight change.

Review of progress note dated an identified date indicated resident #028 had an identified weight change and was refusing identified food and fluid intakes. The RD initiated an identified nutrition intervention. Review of progress note dated an identified date approximately a month later indicated resident #028 had an identified significant weight change over a period of one month with a possible identified cause related to food intake. Further Review of resident #028's clinical records identified he/she had an identified significant weight change over an identified three months period.

Review of the home's nutrition care services policy related to Nutrition Care Monitors (#D006, January 2014), identified nursing staff to monitor resident nutrition status on an

ongoing basis by documenting food and fluid intake.

Review of resident #028's physical copy of care records for food and fluid intake for two identified months including POC documentation at the time of the inspection, did not identify monitoring of the identified nutrition intervention offered to resident #028.

Interview with the RD identified food and fluids offered to residents in the home included snacks and nourishments, meals, and oral nutrition supplements such as Boost juice beverages. The RD identified food and fluid intake was monitored in the home for all residents through flow sheets and POC documentation. Upon review of oral nutrition supplement monitoring, the RD indicated he/she relied on staff reporting for monitoring the intake and acceptance of oral nutrition supplements prescribed to residents in the home and confirmed these were not included in the process for monitoring and documented food and fluids accepted by residents in the home. Interview with the RD confirmed the home did not have a system in place to monitor and evaluate the intake such as the identified nutrition intervention for resident #028.

Interview with the CNM confirmed oral nutrition supplements prescribed to residents in the home were included in the food and fluids offered to residents and reiterated food and fluid intake is monitored through documentation in flow sheets and POC. The identified nutrition intervention for resident #028 was reviewed with the CNM. The CNM confirmed resident #028's intervention was not monitored or evaluated through a system in the home. The CNM confirmed the home did not have a system in place to monitor the intake of oral nutrition supplements such as the identified nutrition intervention for resident #028. [s. 68. (2) (d)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining service that provides residents with any eating aids and assistive devices required to safely eat and drink as comfortable and independently as possible.

Resident #006 was triggered from stage one for no plan-low BMI through staff interview.

A record review of resident #006's written plan of care revealed the RD updated the plan of care for the resident to have an identified eating aid at meals.

The inspector conducted two identified meal services on an identified date. During both meal service observations, resident #006 did not receive the identified eating aid. On the next day, the inspector conducted another meal service observation and observed DA #161 did not provide the identified eating aid to resident #006.

Review of the diet list posted in the servery titled, "Parkway Diet List (Updated on the date as the above mentioned first two meal service observations)" did not mention the identified eating aid at meals under special devices. The diet list posted in the servery on the next day directed staff to provide the identified eating aid at meals.

Interviews with DA #113 and #161 indicated they follow the Diet List in the servery as the list identifying any special devices a resident required during meal service. Both dietary aides acknowledged that resident #006 did not receive the identified eating aid during the above mentioned meal service observations as the diet list did not direct them to provide the identified eating aid. DA #161 further acknowledged he/she did not follow the diet list during the above mentioned meal service observation as he/she did not provide resident #006 with the identified eating aid during the meal service.

An interview with the RD indicated he/she communicated to the SSM on the "Exit Report by RD" form on an identified date for resident #006 to be provided the identified eating aid at meals. The RD stated resident #006 is able to eat independently and required the identified eating aid.

An interview with the SSM indicated the RD communicated to him/her on the "Exit Report by RD" form on the identified date for resident #006 to be provided with the identified eating aid. The SSM stated he/she will then update the diet list to include the identified eating aid as a special device. The dietary aides are to follow the diet list and provide

residents with the assistive devices. The SSM acknowledged resident #006 did not receive the identified eating aid at meals to eat comfortably and independently as possible. [s. 73. (1) 9.]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the copies of the inspection reports from the past two years for the long-term care home were posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

During the initial tour of the RQI, inspector #664 observed that the home posted copies of the inspection reports on an information board in the main floor hallway, and a copy of the inspection report #2015_168202_0012 issued on October 20, 2015, from the past two years, was not posted.

Interviews with the ED indicated the home is aware of the public copies of the inspection reports from the past two years should be posted in the home, and confirmed the above mentioned copy was not posted as required. [s. 79. (3) (k)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included the nature of the written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant.

The MOHLTC ACTIONline received a call on an identified date from the SDM related to resident #042's care. Further interview with the SDM indicated that he/she had sent a written complaint through email to the SSM on another identified date in the following month related to the resident's identified meal service concerns.

A review of the home's policy "Complaint Procedures", INDEX-ID: LGM-A-040, with a reviewed/revised date of May 2014, indicated under procedure number one: client response/complaint form (LGM-A-040-01) is used to record the facts and action taken.

An interview with the SSM confirmed that he/she received the above written complaint from the SDM of resident #042 through email and considered this email to be a complaint. The SSM indicated he/she is to complete a Client Response Form the email complaint and acknowledged that a form was not completed as per home's policy. [s. 101. (2)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1).

In an interview with the SDM of resident #006, the SDM indicated he/she emailed the DOC, on an identified date, a written complaint regarding an identified staff action towards the resident and concerns regarding identified injuries on the resident.

An interview with the ED indicated that it is the home's process for written complaints received from family, residents and/or SDMs be reported to the Director. The ED acknowledged the email from resident #006's SDM was considered to be a written complaint and should have been reported to the Director along with the written report documenting the response the licensee made to the complainant as per the home's process. [s. 103. (1)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a quarterly review is undertaken of all medication incidents that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, a written record is kept.

A record review of the home's medication incidents from the period of April 2017, to June 2017, revealed the home had six medication incidents.

An interview with the DOC indicated that medication incidents are analyzed and reviewed quarterly during the home's Professional Advisory Committee (PAC) meetings.

A review of the home's PAC meeting minutes dated December 7, 2016, March 8, 2017, and June 7, 2017, did not find documentation on the quarterly analysis and review of the home's medication incidents in order to reduce and prevent medication incidents.

An interview with the CNM indicated medication incidents are reviewed and analyzed quarterly during the PAC meetings. The CNM reviewed the PAC meeting minutes for the dates mentioned above and acknowledged that the minutes did not have written record regarding the quarterly analysis and review of the home's medication incidents. [s. 135. (3)]

Issued on this 7th day of November, 2017

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

Original report signed by the inspector.