Ontario

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

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

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

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


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

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 20, 2016 | 2016_226192_0028 | 027046-16 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

TRI-COUNTY MENNONITE HOMES
200 Boullee St. New Hamburg ON N3A 2K4

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

NITHVIEW HOME
200 Boullee Street New Hamburg ON N3A 2K4

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

DEBORA SAVILLE (192), ALI NASSER (523), AMIE GIBBS-WARD (630), INA REYNOLDS (524)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): September 6, 7, 8, 9, 12, 13, 14, 15, 19, 2016.**

**The following intakes were completed within the Resident Quality Inspection: 033701-15 - Follow-up Inspection related to duty to protect, 032706-15 - Critical Incident C547-000018-15 and C547-000019-15 - related to duty to protect and fall prevention,**

**022593-16 - Critical Incident C547-000006-16 - related to fall prevention and doors in the home.**
**019417-16 - Critical Incident C547-000004-16 - related to Duty to Protect,**
**005461-16 - Critical Incident C547-000002-16, C547-000001-16 - related to Duty to Protect,**
**027362-16 - Critical Incident C547-000007-16 - related to fall prevention and responsive behaviours,**
**031619-15 - Complaint - IL-41544-LO - related to personal support services, plan of care and staffing,**
**019167-16 - Complaint - IL-45229-LO - related staffing, bathing, and transfer techniques,**
**012565-16 - Complaint - IL-44239-LO - related to staffing,**
**012561-16 - Complaint - IL-44237-LO - related to staffing and fall prevention,**
**012423-16 - Complaint - IL-44246-LO, IL-44305-LO - related to staffing, fall prevention and bathing,**
**011922-16 - Complaint - IL44330-LO - related to staffing and safe and secure environment,**
**004226-16 - Complaint - IL-42634-LO - related to staffing,**
**026422-16 - Complaint - IL-46393-LO - related to fall prevention, continence care, bathing and duty to protect, and**
**008847-16 - Complaint - IL-43785-LO - related to continence care and fall prevention.**

**During the course of the inspection, the inspector(s) spoke with residents, family members, the Executive Director, Director of Care, Registered Dietitian, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aides, the Restorative Care Nurse, Resident Life Coordinator, Assistant Directors of Care, Staff Scheduler, and the Maintenance Manager.**

**Inspectors toured the home, observed meal service, medication administration, medication storage areas, recreation activities, reviewed relevant clinical records, reviewed relevant policies and procedures, the provision of resident care, resident-staff interactions, posting of required information and observed general maintenance, cleaning and condition of the home.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**
**Training and Orientation**

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

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

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| LTCHA, 2007 S.O. 2007, c.8 s. 19. (1) | CO #001 | 2015_271532_0025 | 192 |

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

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 not neglected by the licensee or staff.

Review of Critical Incident Report C547-000018-15 indicated that on a specified date resident #026 was found on the floor of their shared bedroom. The report stated that the Registered Nurse (RN) assessed the resident and in his documentation noted that resident #026 had new pain and had sustained a possible injury. Further report was that the resident had sustained an injury. The report, which was submitted by Executive Director #100, also identified concerns with the RN's practice and involvement with the care of the resident following the fall.

Review of the progress notes for resident #026 showed a progress note by the RN which identified an unwitnessed fall and that the resident complained of pain and demonstrated a potential injury. This progress note also stated that a device was used to transfer the resident after assessment. Head Injury Routine was started and endorsed to the coming nurses to call doctor for x-ray and call Substitute Decision Maker (SDM). Endorsed to Personal Support Worker (PSW) to leave resident on bed and offer tray service today until further assessment.

Review of post fall assessment documentation for resident #026 found a Head Injury Routine Vital Signs Form was started. This form showed a re-assessment of resident #026 was done at a specified time, but then was not completed again until four and a half hours later. This review also found no pain assessment was completed at the time of the fall.

Director of Care (DOC) #101 reported to Inspector #630 that the RN who was responsible for the care of resident #026, did not complete an adequate assessment of resident #026 regarding the fall. DOC #101 said that this RN did not notify the attending physician of the fall or the status of the resident and instead notified the staff on the next shift to call the physician and further assess the resident.

Review of the home's Investigation Report identified that the RN working at the time of the fall neglected resident #026. Including transferring resident #026 when the resident demonstrated a potential injury, failing to call for emergency medical services, and failing to treat the residents pain. The report indicated that the RN had acted in a neglectful manner.

DOC #101 told Inspector #630 that the conclusion of the Investigation Committee identified that this RN neglected resident #026 related to the care that was not provided. DOC #101 acknowledged that this identified RN did not completed the required assessments, did not notify the physician or call 911 when a potential fracture had been indicated, that the provision of pain medications was not documented and that the resident's well-being was not taken into account. DOC #101 indicated that this identified RN was no longer working in the home and that it was the expectation that no resident would be neglected by staff.

The licensee failed to protect resident #026 from neglect.

The scope of this area of non-compliance is isolated, the severity of harm is identified to be actual harm/risk. This area of non-compliance was previously issued September 14, 2015 as a Compliance Order. [s. 19. (1)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

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

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**
**1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,**
**i. kept closed and locked,**
**ii.equipped with a door access control system that is kept on at all times, and**
**iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,**
**A. is connected to the resident-staff communication and response system, or**
**B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.**
**O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**
**3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.**
**4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and, was connected to the resident-staff communication and response system, or was connected to an audio visual enunciator that was connected to the nurses' station nearest to the door and had a manual reset switch at each door.

Observation of the doors to the North stairwell on the second floor identified that when opened using a key pad, the door could be left open for an indefinite period of time with no audible alarm or response from staff.

Interview with Personal Support Workers (PSW) on the first and second floor confirmed that the doors to stairwells were locked and could be opened by activating the key pad. The PSW's stated that the door being held open did not activate an audible alarm, did not activate the resident-staff communication and response system or any other audible system that could only be cancelled at the point of activation.

Review of Critical Incident C547-000006-16 identified that on a specified date resident #036 was found on the first landing.

During interview with Maintenance Manager #130 he stated that no doors leading to stairwells in the home or to the outside of the home, had audible alarms that allowed calls to be cancelled only at the point of activation and were connected to the resident-staff communication and response system.

It is noted that the licensee had submitted a request for proposal (RFP) related to the resident -staff communication and response system which included alarms for all doors leading to stairwells and the outside of the home. A date for completion of the approved RFP could not be confirmed by Maintenance Manager #130.

The licensee failed to ensure that doors leading to stairways were equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation.

The scope of this area of non-compliance is widespread, the severity of harm is actual harm/risk. This area of non-compliance was previously issued in September 2015 as a WN. [s. 9. (1)]

***Additional Required Actions:***

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

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

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

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

**Findings/Faits saillants :**

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

A clinical record review for resident # 009 with Assistant Director of Care (ADOC) #125 revealed that resident #009 was assessed to have an area of altered skin integrity at the time of admission.

On a specified date, a Head to Toe assessment revealed that resident #009 had additional areas of altered skin integrity.

ADOC # 125 confirmed that resident #009 had developed new areas of altered skin

integrity from the time of admission.

ADOC #125 said that the expectations for registered staff, as per the skin and wound program policy reviewed November 2015, under procedure for residents with altered skin integrity was that when a new area was identified the registered staff would initiate a baseline assessment using a clinically appropriate assessment instrument.

Also under the Skin and Wound Care Management Protocol reviewed July 2015, the procedure for registered staff under number 2. stated; "with a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds the nurse wound conduct a skin assessment and then initiate the weekly assessment."

A clinical record review for resident #009 revealed that there was no skin and wound assessment completed and no weekly assessments were initiated for the newly identified areas of altered skin integrity.

ADOC #125 said that the skin and wound assessments were not completed for newly identified areas of altered skin integrity.

The scope of this area of non-compliance is isolated, the severity is identified to be a two, minimal harm or potential for actual harm. There is a history related to this area of non-compliance: September 14, 2015, VPC; October 7, 2014, VPC; April 30, 2014, CO . [s. 50. (2) (b) (i)]

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

A clinical record review with ADOC #125 revealed that resident #007 had specified areas of altered skin integrity.

A clinical record review for a nine month period, revealed that the resident had received a skin and wound assessment on 10 out of the 37 (27%) weeks.

In an interview, ADOC #125 said that there was no written record to confirm that the weekly skin assessments for the identified areas of altered skin integrity were completed by the registered nursing staff.

ADOC #125 said that it was the expectation that a skin assessment would be completed on a weekly basis.

The licensee failed to ensure that resident #007 who exhibited altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds had been assessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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

A clinical record review with ADOC #125 revealed that resident #010 had identified areas of altered skin integrity.

A clinical record review over a specified nine month period revealed that the resident had received 22 out of the 37 (60%) weekly skin assessments that were to have been completed.

In an interview, ADOC #125 said that there was no written record to confirm that the weekly skin assessments for the identified areas were completed by the registered nursing staff.

ADOC #125 said that it was the expectation that a skin assessment would be completed on a weekly basis.

The licensee failed to ensure that resident #010 who exhibited altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds had been assessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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

A clinical record review for resident #009 with ADOC #125 revealed that resident #009 was admitted with an area of altered skin integrity.

On a specified date, a Head to Toe assessment revealed that resident #009 had additional areas of altered skin integrity.

A clinical record review for resident #009 with ADOC #125 revealed that 15 out of the 35 (35%) weekly skin and wound assessments were completed.

ADOC #125 said she acknowledged "deficiencies and non-compliance within the skin and wound program" as the new lead of program, she would "work to address and resolve those concerns to ensure residents were safe and receiving treatments as needed."

The scope of this area of non-compliance is widespread in that three of three residents reviewed failed to have weekly wound assessments completed. The severity is identified to be a two with minimal harm or potential for actual harm. There is a history related to this area of non-compliance: August 23, 2016, VPC; September 14, 2015, VPC; April 30, 2014, CO. [s. 50. (2) (b) (iv)]

***Additional Required Actions:***

***CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

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

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

**Findings/Faits saillants :**

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

The plan of care for resident #039 stated under Sleep Patterns, that the resident was to receive their specific bedtime routine.

On a specified date, the home was notified by the Substitute Decision Maker (SDM) that Personal Support Worker #132 had not provided the residents specific bedtime routine. The PSW was argumentative with resident #039, stating that she knew the resident's routine.

Telephone interview with PSW #133, who was present at the time of the incident and whom the resident indicated had tried to advocate for them during the provision of care stated that the care was not provided in the manner she had seen it provided by other PSW's working with resident #039. PSW #133 stated that PSW #132 would not listen to the residents efforts to request how their care was provided.

The licensee failed to ensure that resident #041 was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: 1. Every resident had the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

It was reported by the home through Critical Incident C547-000002-16 that on a specified date Personal Support Worker (PSW) #132 had treated resident #042 in a disrespectful manner.

During interview with PSW #133, she stated that resident #042 did not appear to waken, but was turning their head from side to side as if to resist the actions of PSW #132.

The licensee failed to ensure that resident #042 was treated with courtesy and respect

and in a way that fully recognized the resident's individuality and respected the resident's dignity.

The scope of this area of non-compliance is isolated. The severity is a two with minimal harm or potential for actual harm. There is no compliance history related to this area of non-compliance. [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 ensuring that every resident has the right to be treated with courtesy and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.***

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**WN #5: 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).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure the there was a written plan of care for each resident that set out clear directions regarding restraints for staff and others who provide direct care to the resident.

Observations on a specified date, found resident #026 had a specified device in place and during continuous observation between 0945 hours and 1155 hours this resident did not have the device released or their body repositioned in the chair by staff in the home.

Review of the clinical record for resident #026 identified that their was a physician's order for the specified device. The electronic plan of care in Point Click Care (PCC) did not include the device as an intervention or provide direction for staff regarding frequency of checks or repositioning. The printed plan of care located at the nursing station on third floor, also did not include the device as an intervention. The Point of Care (POC) tasks identified the device, but did not identify frequency for repositioning.

The printed plan of care for resident #026 was reviewed with Personal Support Worker (PSW) #121 and she acknowledged that this version available for staff was printed on a specified date, and it did not include use of the specified device for resident #026. PSW #121 reported that PSW staff referred to the printed plan of care at times.

During an interview with PSW #122 it was reported that she would look in the plan of care for direction regarding device use for residents. PSW #122 reported that resident #026 did have a device. PSW #122 reported the PSWs chart whether repositioning was done within POC tasks for the device but it did not specify the time frame that repositioning was to be done.

During an interview with PSW #123 she reported that that she did not reposition resident #026 during a specified time period.

Restorative Care Nurse #110 told Inspector #630 that resident #026 did have a device in place and resident #026 could not remove the device independently. Reviewed electronic plan of care and POC with Restorative Care Nurse #110 and she acknowledged that they did not identify the frequency that staff were to release the device and reposition resident #026. She indicated that it was the expectation in the home that the device would be included in the plan of care and clear direction given to staff regarding repositioning.

DOC #101 told Inspector #630 that it was the expectation in the home that the plan of care would provide clear direction for staff regarding the use of specified devices, including clear direction for frequency of repositioning. DOC #101 also said that the hard copy of the plan of care should be consistent with the electronic plan of care to ensure clear direction for staff.

The scope of this area of non-compliance is isolated, the severity is a two, minimal harm or potential for actual harm. There is a history related to this area of non-compliance: September 2015, VPC; April 17, 2015, VPC; June 11, 2014, VPC; April 30, 2014, WN. [s.

6. (1) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring 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, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any policy put in place in the home was complied with.

Observations on September 7, 2016, found one electric toothbrush, one manual toothbrush, one electric razor and one bottle of soap in the shared bathroom of a specified room and these items were not labelled with the resident's name.

Observations on September 7, 2016, found one manual toothbrush, one container of toothpaste, one hairbrush, and one bar of soap in the shared bathroom of a specifed room and these items were not labelled with the resident's name.

During an interview PSW #105 reported that residents' personal items were to be

labelled by the staff person who received the item or started the item for the resident. She identified that all resident personal care items were not labelled on the third floor including toothbrushes, razors and hairbrushes.

Reviewed policy titled "ADL: Hygeine & Grooming Clothing Maintenance/labeling" with effective date of July 2008. This policy stated "personal items to be labeled by admitting or assigned HCA/PSW" and "this is checked on a regular basis according to the facility system."

DOC #101 indicated to Inspector #630 that it was the expectation in the home that all personal care items would be labelled for residents as per the home's policy. She reported that the process they had in place was not effective as the labels were coming off and they started a new process this week. A staff person was in the process of labeling each resident's items. [s. 8. (1)]

2. The licensee has failed to ensure that any policy put in place in the home was complied with.

Review of Critical Incident Report C547-000018-15 indicated that resident #026 was found on the floor. The report stated that the "RN assessed the resident and in his documentation noted that resident #026 had pain and appeared to be injured. Resident #026 was transferred using a device and was later transferred to hospital where injury was confirmed. The report, which was submitted by Executive Director #100, also identified concerns with the RN's practice and involvement with the care of resident #026 following the fall.

Review of post fall assessment documentation for resident #026 found a "Head Injury Routine Vital Signs Form" was started at the time of the fall. This form showed a re-assessment of resident #026 was done with four and a half hour time span between assessments. This review also found no pain assessment was completed.

Review of the home's policy titled "Falls Prevention Program" with effective date "June 2011" regarding "Post Fall Assessment and Management" included the following directions:

2. Do not move the resident if there was suspicion or evidence of injury, until a full head to toe assessment had been conducted and appropriate action determined (e.g. transfer to hospital)

4. Notify the attending physician, POA/SDM of the fall, interventions and status of the resident.
6. Monitor every hour for the first four hours

DOC #101 reported to Inspector #630 that the RN who was responsible for the care of resident #026 did not complete an adequate assessment of resident #026 regarding the fall. DOC #101 also said that this RN did not notify the attending physician of the fall or the status of the resident and instead notified the staff on the next shift to call the physician and further assess the resident.

Review of the home's Investigation report identified that the RN working at the time of the fall did not follow the policies and procedures in the home regarding post fall care including moving a resident with injury and failing to call emergency services when a resident had fallen and exhibited an increase in pain.

Inspector #630 reviewed the "Head Injury Routine Vital Signs Form" form for resident #026 with DOC #101 and she acknowledged this assessment was incomplete. DOC #101 indicated that it was the expectation in the home that the physician was to be notified of all falls and injuries related to falls and that assessments were completed as per the home's policy.

The scope of this area of non-compliance is isolated, the severity is identified to be a three, actual harm or risk. There is a history of non-compliance related to area of legislation; Aug 23, 2016, WN; January 2015, VPC; October 2014, VPC; November 2013, VPC. [s. 8. (1) (a),s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that any plan, policy, protocol, procedure, strategy or system, put in place, is complied with, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

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

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

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

**Findings/Faits saillants :**

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

A) The licensee's policy titled Abuse and Neglect of Residents - Zero Tolerance dated as reviewed January 2016, stated under Investigation and Reporting of Abuse and Neglect that "employees who are reporting that they have witnessed or suspect alleged incidents of resident abuse or neglect shall report any witnessed, suspected, or alleged abuse to the supervisor/manager, Director of Care, Director of Support Services or the Executive Director immediately".

On a specified date, Registered Practical Nurse #113 identified that resident #039 had

sustained an injury and was alleging that a staff member had provided care against their wishes, causing pain and injury.

During interview with Registered Practical Nurse #133 she stated that she did not notify the Registered Nurse (RN) who would have been her supervisor on the specified date, stating that there was an RN in the home, but "often on weekends it is a RN from an agency and we (RPN's) help them more than they help us." RPN #133 also stated she had not notified the manager on call about the allegation of abuse from resident #039.

B) The licensee's policy titled Abuse and Neglect of Residents - Zero Tolerance dated as reviewed January 2016 stated under Clinical Staff "responsible for the care of the resident harmed by the abuse or neglect shall conduct a head to toe physical assessment on the alleged victim and document findings if physical abuse is alleged."

On a specified date Registered Practical Nurse #113 identified that resident #039 had sustained an injury and was alleging that a staff member had provided care against their wishes, causing pain and injury.

Record review identified a progress note that stated that resident #039 had a specified injury that had not been identified by staff the previous day. Further review of the medical record identified that a Head to Toe assessment was not conducted for resident #039 until two days later.

During interview Director of Care #101 stated that it would be her expectation that a Head to Toe assessment would have been completed for resident #039 immediately on discovering the injury and hearing the allegation of abuse made by the resident.

The licensee failed to comply with the Abuse and Neglect of Residents - Zero Tolerance policy when the injury and allegation of abuse voiced by resident #039 were not reported to the supervisor, Director of Care, Director of Support Services or the Executive Director immediately and when the Head to Toe Assessment was not completed when an injury allegedly related to abuse by a staff member was identified.

The scope of this area of non-compliance is isolated, the severity is identified to be a two, minimal harm or potential for actual harm. There is no compliance history related to this area of non-compliance. [s. 20. (1)]

2. The licensee has failed to ensure that the policy to promote zero tolerance of abuse

and neglect of residents provide for a program, that complied with the regulations, for preventing abuse and neglect and contained an explanation of the duty under section 24 of the Act to make mandatory reports.

Review of the licensee's policy titled Abuse and Neglect of Residents - Zero Tolerance dated as reviewed January 2016, failed to identify an explanation of the duty under section 24 to make mandatory reports.

On a specified date, resident #039 reported to Registered Practical Nurse (RPN) #113 that they had sustained an injury and pain as a result of care provided by a staff member. The RPN made aware of the incident and all Registered Nurses (RN's) and RPN's working on the specified dates, who were aware of the incident, failed to report the incident to the Director. The incident was reported by the Director of Care two and a half days after it was first identified.

During interview with Executive Director #100 she stated that the home was aware that the policy did not reflect the requirements under Section 24 and that a new policy had been created that included this information but staff had not yet been trained on the new policy and it was not currently in effect.

The licensee failed to ensure that the policy titled Abuse and Neglect of Residents - Zero Tolerance dated as reviewed January 2016 included the requirements under Section 24 of the Act.

The scope of this area of non-compliance is isolated, the severity is identified to be a two, minimal harm or potential for actual harm. There is no compliance history related to this area of non-compliance. [s. 20. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the policy to promote zero tolerance of abuse and neglect of residents provides for a program, that complied with the regulations, for preventing abuse and neglect and contained an explanation of the duty under section 24 of the Act to make mandatory reports; ensuring that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

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

**s. 23. (1) Every licensee of a long-term care home shall ensure that,**
**(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
**(i) abuse of a resident by anyone,**
**(ii) neglect of a resident by the licensee or staff, or**
**(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
**(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
**(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that was reported was immediately investigated.

On a specified date, resident #039 was observed by Registered Practical Nurse #113 to have an injury.

During interview on a specified date, although unclear about the time frame resident #039 was able to recall the incident when they were injured.

During interview with Director of Care (DOC) #101 she stated that the home had not conducted an investigation into the incident after resident #039 alleged that someone providing their care had caused pain and injury. DOC #101 indicated that the police had investigated the incident and acknowledged that she was aware the home should have done a parallel investigation of the allegation.

During interview with Executive Director (ED) #100 she stated that an investigation had been initiated but then identified that no staff were interviewed who had worked with the accused, the accused was not interviewed. There was no record of an investigation. ED #100 stated that an investigation was to be done by the police and confirmed that the home had not completed any investigation into the allegation of abuse to resident #039. ED #100 also confirmed that no action had been taken to protect other residents of the home as the accused staff member was scheduled and worked after the allegation of abuse was identified.

The licensee failed to ensure that every alleged incident of abuse of a resident by anyone that the licensee knew of or that was reported was immediately investigated.

The scope of this area of non-compliance is isolated, the severity of harm is a two, minimal harm or potential for actual harm. There is a history of non-compliance related to this area of the legislation: September 2015, WN; April 30, 2014, CO. [s. 23. (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 ensuring that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.***

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**WN #9: 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 the person who had reasonable grounds to suspect that abuse of a resident by anyone, that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

On a specified date, immediately following report, Registered Practical Nurse (RPN) #113 became aware of an injury to resident #039 who reported an allegation of abuse from a staff member.

Review of the medical record identified that RPN #113 had documented the observations and residents statement During interview with RPN #113 she stated that she had not communicated the incident to the Registered Nurse on duty as it was an agency nurse.

During telephone interview with the agency RN #131 working on the specified date, she confirmed that she was the most responsible person in the building and that she was aware of the allegation of abuse made by resident #039. Agency RN #131 was unable to recall when she had been made aware of the incident and stated that she did not notify the on-call manager as she believed that had already been done.

Review of the Critical Incident submitted by the licensee two days following the incident, identified that the incident was reported approximately ten hours after the Director of Care had been made aware of the incident.

During interview with ED #100, she stated that she had not called the Ministry of Health to notify the Director of the allegation of abuse when she became aware of it.

During interview with DOC #101 she stated that she had been made aware of the incident as soon as she arrived in the home and confirmed that no call was placed to the Ministry of Health to notify the Director or the allegation and that the incident report was not completed and submitted immediately.

Review of the shift report identified the progress notes by RPN #113 documenting the allegation of abuse and injury to resident #039 were included on the shift report.

During interview with DOC #101 she stated that it would be the expectation for all Registered Nurses (RN), including Agency RN's to review the electronic shift reports.

The licensee failed to ensure that staff of the home, including the most responsible registered nurse, who had reasonable grounds to suspect abuse of a resident by anyone, that resulted in harm or risk of harm, was immediately reported to the Director. [s. 24. (1)]

2. The licensee has failed to ensure that any 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 that had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

On a specified date, the family of resident #041 reported allegations of emotional abuse by Personal Support Worker #132 when the resident's requests to have their care provided in a specific manner were not acknowledged and complied with resulting in the resident, who was totally dependent on staff, feeling unsafe and having a poor night.

During interview with Executive Director #100 she stated that the Director had not been notified of the allegation of abuse for a seven day period, when the after-hours number was called.

The licensee failed to ensure that the Director was immediately notified of an allegation of emotional abuse involving resident #039.

The scope of this area of non-compliance is isolated, the severity is identified to be a one, minimal risk. There is a history of non-compliance related to this area of non-compliance: April 2014, VPC. [s. 24. (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 ensuring that any person who had reasonable grounds to suspect that abuse of a resident by anyone, that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.***

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

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

**s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:**
**1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
**2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
**3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).**
**4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to keep a written record relating to evaluation of the skin and wound management program that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A review of the skin and wound management program with DOC #101 revealed that there was no written record of the annual evaluation of the skin and wound program that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

DOC #101 said that she expected to complete program evaluations accordingly as she was now fully enrolled in her role as DOC.

The scope of this area of non-compliance is isolated, the severity is identified to be a two, minimal harm or potential for actual harm. There is a compliance history related to this area of non-compliance: September 2015, WN. [s. 30. (1) 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 ensuring that a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented is kept by the licensee, to be implemented voluntarily.***

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the staffing plan promoted continuity of care by minimizing the number of different staff members who provided nursing and personal support services to each resident and that the staffing plan would be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A review of the staffing plan with Executive Director (ED) #100 revealed that the plan required 27 Personal Support Workers (PSW) for the full day, 12 for day shift, 9 for evening shift and 6 for night shift.

ED #100 said there was a total of 14 vacant lines for PSWs; 1 permanent full time, 11 permanent part times and 2 temporary full time lines. ED #100 said that the Human Resources (HR) department had been trying to recruit, but with no success, "which left us with one choice, which was using agency staff."

ED #100 said that the HR department had been working on recruiting staff but there were no receipts, emails, copies of postings or any other documentation to support that postings had been posted in newspapers or on websites.

ED #100 said that as of October all Registered Nurse (RN) lines would be filled. Registered Practical Nurse (RPN) lines were usually filled. The challenge was with PSWs and the number of agency staff that had to be used.

Inspector #523 reviewed with ED #100 the numbers of agency staff used between June 1st, 2016 and September 11, 2016, revealed the following:

June 2016: 42 RN shifts out of 90 shifts (46 %), 1.5 RPN shifts out of 210 shifts (0.7%) and 92 PSW shifts of the 810 shifts (11.35%) were covered by agency staff.

July 2016: 30 RN shifts out of 93 shifts (32 %), 4.5 RPN shifts out of 217shifts (2%) and 134 PSW shifts of the 837 shifts (16%) were covered by agency staff.

August 2016: 19 RN shifts out of 93 shifts (20.5%), 13 RPN shifts out of 217shifts (6%) and 83 PSW shifts of the 837 shifts (10%) were covered by agency staff.

September 1to11, 2016: 4 RN shifts out of 33 shifts (12 %), 6.5 RPN shifts out of 77shifts (8.5%) and 25 PSW shifts of the 297 shifts (8.5%) were covered by agency staff.

From June 1, 2016 to September 11, 2016; 95 RN shifts (31%), 25.5 RPN shifts (3.5%) and 334 PSW shifts (12%) were covered by agency staff.

ED #100 confirmed these numbers and said she was not surprised as the home needed to fill vacancies. ED #100 said that having a variety of agency staff come in to cover available shifts did not promote the continuity of care to the residents as "we were not sure if the same staff member would be providing nursing and personal support services to the same residents."

ED #100 said that the staffing plan was not evaluated and updated annually in accordance with evidence-based practices.

ED # 100 confirmed that the staffing plan with the vacant lines did not promote the continuity of care to the residents and that the plan should have been evaluated and updated at least annually in accordance with evidence-based practices.

The scope of this area of non-compliance is a pattern, the severity is identified to be minimal harm or potential for actual harm. There is a history related to this area of non-

compliance; September 2015, WN. [s. 31. (3)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the staffing plan promotes continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident and that the staffing plan be evaluated and updated at least annually in accordance with evidence-based practices and if there are none, in accordance with prevailing practices, to be implemented voluntarily.***

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**WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement**

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

**s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a PASD (which had the effect of limiting or inhibiting a resident's freedom of movement and the resident was not able to release himself from the PASD) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

On a specified date, Inspector #630 observed resident #026 using a specified device.

PSW #123 told Inspector #630 that she used the specified device to change the positioning of the resident.

Clinical record review identified that the device was not included in any part of the plan of care for resident #026 including the physician's order, the electronic plan of care, the hard copy of the plan of care, the Kardex or Point of Care (POC). This review also found a progress note by the Occupational Therapist about the use of the device but this not did not include direction for staff.

Restorative Care Nurse #110 reported to Inspector #630 that resident #026 did use a specified device and this had the potential to limit movement but it was not being used as a restraint as it was for positioning. Restorative Care Nurse #110 acknowledged that this PASD was not included in the plan of care for resident #026 but was used by staff as an intervention.

DOC #101 told Inspector #630 that it was the expectation in the home that the plan of care would provide direction for staff for residents using PASDs, including the use of specified devices. DOC #101 told Inspector #630 that the assessment regarding the use of the device had not been completed for resident #026 and therefore this intervention had not been included in the plan of care. DOC #101 said it was the expectation in the home that the assessment would be completed and the plan of care would include any PASD used for residents.

The scope of this area of non-compliance is isolated, the severity is identified to be a two, minimal harm or potential for actual harm. There is no compliance history related to this area of non-compliance. [s. 33. (3)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that a PASD (which has the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able to release himself) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.***

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**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management**

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

**s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when a resident has fallen the resident was assessed and, if required, a post-fall assessment conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

On a specified date, Personal Support Worker (PSW) #114 reported to Inspector #630 that they had witnessed resident #027 fall. PSW #114 reported after the fall resident #027 seemed anxious and that they had an injury.

Observations of resident #027 found an injury.

Review of the of progress notes for resident #027 showed no "fall note" was completed that day. A note was documented which stated family had been notified and assessments completed, medical attention completed.

Review of post fall assessment documentation for resident #027 found a "Head Injury Routine Vital Signs Form" was started. This form showed reassessment was not done at over a specified 45 minute period as unable to obtain; reassessment was not done over a nine hour period as the resident was documented as "sleeping". This review found no pain assessment, no head to toe skin assessment and no "post fall investigation" assessment were completed for this fall. The review also found the TAR was not updated to reflect assessment or monitoring of the injury from this fall.

Review of the home's policy titled "Falls Prevention Program" with effective date "June 2011" regarding "Post Fall Assessment and Management" included the following directions:
1. Complete head to toe assessment.
5. Monitor every hour for the first four hours and then every four hours for 24 hours post fall for signs of neurological changes.
7. Complete an incident investigation and an incident report including all contributing factors.
10. Document in the progress notes: date and time of the incident, location of the incident, whether the fall was witnessed or unwitnessed, status of the resident (e.g. type and severity of injury).

Inspector #630 reviewed the post fall documentation with DOC #101 regarding the fall for resident #027. DOC #101 acknowledged that the registered staff did not complete an assessment of this fall as there was no pain assessment, no head to toe skin assessment, no "post fall investigation" assessment and the "Head Injury Routine Vitals Signs Form" was incomplete. DOC #101 also indicated that the TAR was not updated regarding the injury and this would have been an expectation as part of the post fall assessment documentation. DOC #101 indicated that it was the expectation in the home that post fall assessments were completed as per the home's policy.

The scope of this area of non-compliance is isolated, the severity is identified to be a two, minimal harm or potential for actual harm. There is no compliance history related to this area of non-compliance. [s. 49. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.***

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**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

During observation it was noted that the door to the first floor utility room which was equipped with a keypad, had been left open and the light was on. Upon entering the room a shelf containing the following labeled hazardous substances was identified; Biosorb 2000 Fluid Control with chlorine, identified to be an eye and skin irritant; Grease Trap identified on the handwritten label to have a Health Risk of 1 and the need for Personal Protection and Virex 256 - one step disinfectant cleaner and disinfectant.

Personal Support Worker #116 confirmed that the door was to be kept closed and secured. She stated, while turning off the light and closing the door, that staff "try to keep the door close so no residents go in there".

The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

The scope of this area of non-compliance is isolated, the severity is identified to be a two, minimal harm or potential for actual harm. There is a history of non-compliance: September 2015, VPC; April 17, 2015, VPC. [s. 91.]

***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 ensuring that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.***

**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance**
**Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,**
**(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;**
**(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;**
**(c) identifies measures and strategies to prevent abuse and neglect;**
**(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and**
**(e) identifies the training and retraining requirements for all staff, including,**
**(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and**
**(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the licensee's written policy to promote zero tolerance of abuse and neglect of residents identified measures and strategies to prevent abuse and neglect.

Review of the licensee's policy titled Abuse and Neglect of Residents - Zero Tolerance dated as reviewed January 2016, failed to identify measures and strategies to prevent abuse and neglect.

During interview with Executive Director #100 it was confirmed that the policy failed to identify measures and strategies to prevent abuse and neglect. ED #100 stated that it had been identified that this information was missing from the policy, that a new policy had been created, but was not in effect as staff had not been trained on the new policy.

The licensee failed to ensure that the policy titled Abuse and Neglect of Residents - Zero Tolerance identified measures and strategies to prevent abuse and neglect. [s. 96. (c)]

2. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identified the training and retraining requirements for all staff including: i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and ii. situations that may lead to abuse and neglect and how to avoid such situations.

Review of the licensee's policy titled Abuse and Neglect of Resident - Zero Tolerance with a review date of January 2016 failed to identify the training and retraining requirement for all staff including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care and situations that my lead to abuse and neglect and how to avoid such situations.

During interview with Executive Director #100 she stated that she did not believe this policy addressed the above training needs and that she believed the revised policy did address these items. Executive Director #100 confirmed that staff had not been trained on the new policy and that it was not yet in use in the home.

The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identified the specified training and retraining requirements.

The scope of this area of non-compliance is isolated, the severity is identified to be a two, minimal harm or potential for actual harm. There is no compliance history related to this area. [s. 96. (e)]

***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 ensuring that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, identifies measures and strategies to prevent abuse and neglect; (e) identifies the training and retraining requirements for all staff, including, (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations, to be implemented voluntarily.***

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**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,**
**(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;**
**(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;**
**(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;**
**(d) that the changes and improvements under clause (b) are promptly implemented; and**
**(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

It was requested of ED #100 and DOC #101, that the home provide to the Inspector the evaluation of the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents. No annual evaluation was provided.

During interview with DOC #101 she stated that no annual evaluation of the effectiveness of the policy to promote zero tolerance of abuse and neglect of residents had been completed.

The scope of this area of non-compliance is isolated, the severity is identified to be a two, minimal harm or potential for actual harm. There is a history of non-compliance related to this area: September 2014, WN. [s. 99. (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences, to be implemented voluntarily.***

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: the complaint investigated and resolved where possible, and a response to complainant that meets the requirements of the legislation within 10 business days of the receipt of the complaint.

Review of a "We're Listening" form for a specified date, showed an identified family member had written a complaint regarding the staffing levels in the home.

Review of the "Quality Improvements Action Form" identified this "We're Listening" form as a "written concern from family/resident". This form did not include documentation of an investigation into the concern or that a response was made to the identified family member within 10 days of the receipt of the complaint. This form listed that DOC #101 had completed the "Corrective Action" on a specified date.

DOC #101 reported to Inspector #630 that she had reviewed the "We're Listening" form regarding the family member complaint. DOC #101 further said she viewed this written concern as a communication from the family member versus a complaint. She reported she was not working on the date Corrective Action had been reported on the form, and did not speak to this identified family member on that day. DOC #101 further reported that she recalled speaking with this family member about the concern but could not remember the date. DOC #101 acknowledged to Inspector #630 that details of the concern, the date of the follow-up with the family and the response of the family were not documented.

ED #100 told Inspector #630 that the "Internal Complaints Procedure" was how the home communicated to family members and residents the process for making written complaints in the home. She acknowledged that this document identified the "We're Listening" form as a means for communicating complaints to the management in the home. ED #100 acknowledged that the "We're Listening" form was a written complaint and that it had not been investigated or responded to within 10 days. ED #100 reported the home was working on a new policy and process regarding complaints and it was the expectation that family complaints would be investigated and responded to in accordance with the legislation.

The scope of this area of non-compliance is isolated, the severity is identified to be a two, minimal harm or potential for actual harm. There is a history related to this area of non-compliance; January 12, 2015, WN. [s. 101. (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 ensuring that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, to be implemented voluntarily.***

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**WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 222. Exemptions, training**

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

**s. 222. (2) The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services. O. Reg. 79/10, s. 222 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the persons described in clauses (1) (a) to (c)

are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services.

Under s. 222(1)(a) refers persons who fall under clause (b) and (c) of the definition of staff in subsection 2(1) of the Act.

Under s. 2(1) definition of staff (b) mean persons who work at the home pursuant to a contract or agreement with the licensee. (c) means persons who work at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party.

Review of the schedule and interview with the Director of Care (DOC) #101, identified that the home used Personal Support Workers, Registered Practical Nurses and Registered Nurses from two contracted employment agencies.

During interview with DOC #101 she stated that no information from the home was shared with contracted agencies related to the Resident's Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports, the protections afforded under section 26, fire prevention and safety, emergency and evacuation procedures or infection prevention and control.

Assistant Director of Care (ADOC) #125 stated in interview that they were at times responsible for completing orientation of Registered Nurses contracted by employment agencies to work in the home. She stated that she had not orientated any Personal Support Workers to the home and that for registered staff orientated there was no review of the licensee's abuse and neglect policy.

During interview with Staff Scheduler #126 she stated that Personal Support Workers received no orientation before working in the home. She indicated that efforts were made to pair the staff member with regular employees of the home.

On a specified date, resident #039 was abused by a Personal Support Worker who worked for an agency. The allegation was reported to Registered Practical Nurse #113 who stated that they did not report the allegation to the Registered Nurse (RN) as the RN was an agency nurse and that they often require assistance from the RPN's employed by the home. The accused PSW continued to work with residents of the home for two shifts, after the allegation of abuse was made by resident #039.

Review of the schedule identified that during the specified month, 11% of staff working in the home were agency staff. On the specified date, 32% of the Personal Support Workers and 100% of Registered Nurses working in the home were agency staff . On the following day, 28% of PSW's and 100% of the Registered Nurses working in the home were agency staff.

The licensee failed to ensure that agency staff working in home were provided required information before working the home.

The scope is widespread in that none of the agency staff working in the home were made aware of the home's policy to promote zero tolerance of abuse and neglect of residents. The severity is minimal harm or potential for actual harm in that resident #039 was abused by agency staff working in the home. There is no compliance history related to this area of non-compliance. [s. 222. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services, to be implemented voluntarily.***

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**WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

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

**s. 229. (5) The licensee shall ensure that on every shift,**
**(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were recorded and that immediate action was taken as required.

A clinical record review showed resident #012 was assessed as having had an infection during the observation period for the Resident Assessment Instrument Minimum Data Set (RAI MDS) assessment with a specified Assessment Reference Date (ARD). A progress note identified that resident #012 had symptoms of an infection. Further review of progress notes identified that resident #012 had an assessment done by nursing which identified symptoms of an infection with the action "note in doctors book". Progress notes showed no further assessment until physician assessment, at which time resident #012 was diagnosed with an Infection and antibiotics were initiated. Progress notes also indicated that resident #012 was not isolated related to the symptoms recorded, during the specified month.

ADOC #125 reported to Inspector #630 that residents in the home would be put into isolation if they had two or more symptoms. She indicated the home used the "Quick Reference Guide for Outbreaks" provided by the Public Health Unit which directed that residents with these symptoms would be in isolation for five days with precautions. She acknowledged that resident #012 did exhibit symptoms of infection and was not placed on isolation. ADOC #125 identified that as soon as the physician was aware of the symptoms she took action but acknowledged there were five days between the onset of documented symptoms and the notification of the physician. ADOC #125 also said to Inspector #630 that there were gaps in the assessments and documentation regarding the symptoms for resident #012 and it was the expectation within the home that the documentation would be completed on each shift, comprehensive assessments of symptoms completed and immediate action taken as required.

The scope of this area of non-compliance is isolated, the severity is identified to be a two, minimal harm or potential for actual harm. There is a history of non-compliance related to this area: September 2015, WN. [s. 229. (5) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that on every shift, symptoms indicating the presence of infection in residents are recorded and that immediate action is taken as required, to be implemented voluntarily.***

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**WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 234. Staff records**

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

**s. 234. (4) The licensee is only required to ensure that the record under subsection (1) includes the matters set out in paragraphs 2, 3 and 4 of that subsection with respect to a staff member who falls under clause (c) of the definition of "staff" in subsection 2 (1) of the Act and,**
**(a) who will provide direct care to residents; or O. Reg. 79/10, s. 234 (4).**
**(b) who does not fall under clauses (2) (a) and (b) of this section. O. Reg. 79/10, s. 234 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a record was kept for each staff member of the home that included at least the following with respect to the staff member who falls under clause (c) of the definition of staff in subsection 2(1) of the Act and who will provide direct care to the residents.

A) Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she was a member, or verification of the staff member's current registration with the regulatory body governing his or her profession.

B) Where applicable, the results of the staff member's criminal reference check under subsection 75(2) of the Act.

C) Where applicable, the staff member's declaration under subsection 215(4).

The licensee had a contract with two employment agencies who provided Registered Nurses, Registered Practical Nurses and Personal Support Workers to the home. These employees who provide direct care to the residents of the home were defined as staff of the home under Section 2(1) of the Act.

During interview with Director of Care #101 it was stated that registration for RN's and RPN's, criminal reference checks and declarations under subsection 215(4) were not available within the home.

The licensee failed to ensure that staff records were maintained at the home for staff who fell under clause (c) of the definition of staff in subsection 2(1) of the Act.

The scope of this area of non-compliance is isolated, the severity is identified to be a two, minimal harm or potential for actual harm. There is no compliance history related to this area of non-compliance. [s. 234. (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 ensuring that the record under subsection (1) includes the matters set out in paragraphs 2, 3 and 4 of that subsection with respect to a staff member who falls under clause (c) of the definition of "staff" in subsection 2 (1) of the Act and, who will provide direct care to residents, to be implemented voluntarily.***

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**WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council**

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

**s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).**

**Findings/Faits saillants :**

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Review of the Residents' Council meeting minutes identified that that during a specified meeting concerns were raised in relation to staffing changes.

A letter from the Resident Life Coordinator #124 to Executive Director #100 these concerns. This letter also included specific comments made by residents about this concern.

During an interview with resident #029 it was reported that the Resident's Council did not receive a written response to their concern regarding the concerns expressed.

Resident Life Coordinator #124 acknowledged that the Residents' Council did not receive a written response to this concern from the licensee within 10 days. She indicated it was

the expectation in the home that written responses would be received within 10 days and these would be shared with the members of the Residents' Council. [s. 57. (2)]

2. Review of specified Resident's Council meeting minutes showed a concern regarding staff training. The written response from the licensee was provided but failed to address the concern.

Resident #029 reported the Resident's Council had discussed concerns regarding the use of agency staff in the home and that she felt this concern had not been addressed.

Resident Life Coordinator #124 indicated that the residents had a discussion regarding concerns about the agency staff in the home and that "a lot of new staff" was referring to the agency staff. The Resident Life Coordinator #124 acknowledged that the written response provided to the Resident's Council did not address the concern.

DOC #101 told Inspector #630 that she had been made aware of the Residents' Council concern regarding staff training and that she responded in writing stating "to be reviewed at next registered staff meeting in September". DOC #101 said that this response meant she would address the need for greater oversight and training by the registered staff for new staff working on the floors and the expectations of what resources the new staff were to reference regarding resident care. She acknowledged that the written response she provided to the residents' council did not provide a response specific to their concerns and acknowledged that the members of the council could have difficulties knowing what she meant by the written response.

The scope of this area of non-compliance is isolated, the severity is identified to be a one, minimal risk. There is no compliance history related to this area of non-compliance. [s. 57. (2)]

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**WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services**

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

**s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,**
**(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks.

A review of the Preventative Maintenance Program with Maintenance Manager #130 revealed that a procedure to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks had not been developed in the home.

A tour of specified rooms completed with Maintenance Manager #130 confirmed corrosion in bathroom sink at drain holes, and chips and cracks on sink.

Maintenance Manager #130 confirmed observations and confirmed that procedures were not developed to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

The scope of this area of non-compliance is isolated, the severity is identified to be a one, minimal risk. There is no compliance history related to this area of non-compliance. [s. 90. (2) (d)]

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**WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**

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

**s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,**
**(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and**
**(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident.

On a specified date, it was identified by Registered Practical Nurse (RPN) #113 that resident #039 had sustained an injury and the resident expressed an allegation of abuse by a staff member.

During interview with the resident the resident was unable to provide specified details about the incident but was able to recall being injured by a staff member.

During interview with RPN #113 she stated that she had discovered the injury and that she had notified resident #039's substitute decision maker (SDM) on the following morning when the SDM had come in to visit the resident. RPN #113 confirmed that the SDM was not immediately notified of the allegation of abuse and injury sustained.

The licensee failed to ensure that the resident's SDM was immediately notified upon becoming aware of alleged abuse that resulted in a physical injury and pain to resident #039. [s. 97. (1) (a)]

2. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within 12 hours upon

becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

On a specified date the home identified an allegation of abuse involving Personal Support Worker (PSW) #131 and resident #042.

Resident #042 was identified in the plan of care to be dependent on the assistance of staff for all other aspects of hygiene.

During interview with Executive Director #100, she stated that the SDM was not notified within 12 hours upon the home becoming aware of an alleged incident of abuse of resident #042.

The scope of this area of non-compliance is isolated, the severity is identified to be a one, minimal risk. There is no compliance history related to this area of non-compliance. [s. 97. (1) (b)]

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**WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act**

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

**s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:**
**2. A description of the individuals involved in the incident, including,**
**i. names of all residents involved in the incident,**
**ii. names of any staff members or other persons who were present at or discovered the incident, and**
**iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(i) names of all residents involved in the incident

The Director of Care submitted Critical Incident C547-000004-16 on June 27, 2016 reporting an allegation of staff to resident abuse.

Review of the critical incident report with Executive Director #100 identified that the incident report completed on a specified date failed to include the name of the resident involved in the allegation of staff to resident abuse.

The Executive Director stated in interview that the resident name was not included on the critical incident report and provided resident #039's name to the Inspector.

The licensee failed to ensure that the report to the Director included the names of all residents involved in an allegation of staff to resident abuse.

The scope of this area of non-compliance is isolated, the severity is identified to be a one, minimal risk. There is no compliance history related to this area of non-compliance. [s. 104. (1) 2.]

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**Issued on this 21st day of October, 2016**

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

**Original report signed by the inspector.**

Ontario

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

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

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

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

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

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du public

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | DEBORA SAVILLE (192), ALI NASSER (523), AMIE GIBBS-WARD (630), INA REYNOLDS (524) |
| **Inspection No. / No de l'inspection :** | 2016_226192_0028 |
| **Log No. / Registre no:** | 027046-16 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Oct 20, 2016 |
| **Licensee / Titulaire de permis :** | TRI-COUNTY MENNONITE HOMES<br>200 Boullee St., New Hamburg, ON, N3A-2K4 |
| **LTC Home / Foyer de SLD :** | NITHVIEW HOME<br>200 Boullee Street, New Hamburg, ON, N3A-2K4 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Elizabeth Klassen |

To TRI-COUNTY MENNONITE HOMES, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure that all residents of the home are protected from abuse by anyone and that residents are not neglected by the licensee or staff of the home.

The plan is to include but is not limited to the following:

i) Review and revision of the program for the prevention of abuse and neglect to ensure that the required policy is reflective of requirements identified in the legislation.

ii) Training of all staff of the home on the revised prevention of abuse and neglect program including the duty under section 24 to make mandatory reports, measures and strategies to prevent abuse and neglect and and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

The plan is to be submitted electronically to the attention of Long Term Care Homes Inspector, Amie Gibbs-Ward at LondonSAO.moh@ontario.ca by November 30, 2016.

**Grounds / Motifs :**

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

Review of Critical Incident Report C547-000018-15 indicated that on a specified date resident #026 was found on the floor of their shared bedroom. The report

stated that the Registered Nurse (RN) assessed the resident and in his documentation noted that resident #026 had new pain and had sustained a possible injury. Further report was that the resident had sustained an injury. The report, which was submitted by Executive Director #100, also identified concerns with the RN's practice and involvement with the care of the resident following the fall.

Review of the progress notes for resident #026 showed a progress note by the RN which identified an unwitnessed fall and that the resident complained of pain and demonstrated a potential injury. This progress note also stated that a device was used to transfer the resident after assessment. Head Injury Routine was started and endorsed to the coming nurses to call doctor for x-ray and call Substitute Decision Maker (SDM). Endorsed to Personal Support Worker (PSW) to leave resident on bed and offer tray service today until further assessment.

Review of post fall assessment documentation for resident #026 found a Head Injury Routine Vital Signs Form was started. This form showed a re-assessment of resident #026 was done at a specified time, but then was not completed again until four and a half hours later. This review also found no pain assessment was completed at the time of the fall.

Director of Care (DOC) #101 reported to Inspector #630 that the RN who was responsible for the care of resident #026, did not complete an adequate assessment of resident #026 regarding the fall. DOC #101 said that this RN did not notify the attending physician of the fall or the status of the resident and instead notified the staff on the next shift to call the physician and further assess the resident.

Review of the home's Investigation Report identified that the RN working at the time of the fall neglected resident #026. Including transferring resident #026 when the resident demonstrated a potential injury, failing to call for emergency medical services, and failing to treat the residents pain. The report indicated that the RN had acted in a neglectful manner.

DOC #101 told Inspector #630 that the conclusion of the Investigation Committee identified that this RN neglected resident #026 related to the care that was not provided. DOC #101 acknowledged that this identified RN did not completed the required assessments, did not notify the physician or call 911 when a potential fracture had been indicated, that the provision of pain

medications was not documented and that the resident's well-being was not taken into account. DOC #101 indicated that this identified RN was no longer working in the home and that it was the expectation that no resident would be neglected by staff.

The licensee failed to protect resident #026 from neglect.

The scope of this area of non-compliance is isolated, the severity of harm is identified to be actual harm/risk. This area of non-compliance was previously issued September 14, 2015 as a Compliance Order. (630)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jan 30, 2017

**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

**Order / Ordre :**

The licensee shall ensure that all doors leading to stairways and to the outside of the home are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and, is connected to the resident-staff communication and response system, or is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

**Grounds / Motifs :**

1. The licensee has failed to ensure that all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and, was connected to the resident-staff communication and response system, or was connected to an audio visual enunciator that was connected to the nurses' station nearest to the door and had a manual reset switch at each door.

Observation of the doors to the North stairwell on the second floor identified that when opened using a key pad, the door could be left open for an indefinite period of time with no audible alarm or response from staff.

Interview with Personal Support Workers (PSW) on the first and second floor confirmed that the doors to stairwells were locked and could be opened by activating the key pad. The PSW's stated that the door being held open did not activate an audible alarm, did not activate the resident-staff communication and response system or any other audible system that could only be cancelled at the point of activation.

Review of Critical Incident C547-000006-16 identified that on a specified date resident #036 was found on the first landing.

During interview with Maintenance Manager #130 he stated that no doors leading to stairwells in the home or to the outside of the home, had audible alarms that allowed calls to be cancelled only at the point of activation and were connected to the resident-staff communication and response system.

It is noted that the licensee had submitted a request for proposal (RFP) related to the resident -staff communication and response system which included alarms for all doors leading to stairwells and the outside of the home. A date for

completion of the approved RFP could not be confirmed by Maintenance Manager #130.

The licensee failed to ensure that doors leading to stairways were equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation.

The scope of this area of non-compliance is widespread, the severity of harm is actual harm/risk. This area of non-compliance was previously issued in September 2015 as a WN. (192)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 30, 2016

**Order # / Ordre no :** 003

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

**Pursuant to / Aux termes de :**

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

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

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

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

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

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

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

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

**Order / Ordre :**

The licensee shall ensure that residents #007, #009 and #010 and all other residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the registered nursing staff.

**Grounds / Motifs :**

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

A clinical record review for resident #009 with ADOC #125 revealed that resident #009 was admitted with an area of altered skin integrity.

On a specified date, a Head to Toe assessment revealed that resident #009 had additional areas of altered skin integrity.

A clinical record review for resident #009 with ADOC #125 revealed that 15 out of the 35 (35%) weekly skin and wound assessments were completed.

ADOC #125 said she acknowledged "deficiencies and non-compliance within the skin and wound program" as the new lead of program, she would "work to address and resolve those concerns to ensure residents were safe and receiving treatments as needed." (523)

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

A clinical record review with ADOC #125 revealed that resident #010 had identified areas of altered skin integrity.

A clinical record review over a specified nine month period revealed that the resident had received 22 out of the 37 (60%) weekly skin assessments that were to have been completed.

In an interview, ADOC #125 said that there was no written record to confirm that the weekly skin assessments for the identified areas of altered skin integrity were completed by the registered nursing staff.

ADOC #125 said that it was the expectation that a skin assessment would be completed on a weekly basis.

The licensee failed to ensure that resident #010 who exhibited altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds had been assessed at least weekly by a member of the registered nursing staff. (523)

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

A clinical record review with ADOC #125 revealed that resident #007 had specified areas of altered skin integrity.
A clinical record review for a nine month period, revealed that the resident had received a skin and wound assessment on 10 out of the 37 (27%) weeks.

In an interview, ADOC #125 said that there was no written record to confirm that the weekly skin assessments for the identified areas of altered skin integrity were completed by the registered nursing staff.

ADOC #125 said that it was the expectation that a skin assessment would be completed on a weekly basis.

The licensee failed to ensure that resident #007 who exhibited altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds had been assessed at least weekly by a member of the registered nursing staff.

The scope of this area of non-compliance is widespread in that three of three residents reviewed failed to have weekly wound assessments completed. The severity is identified to be a two with minimal harm or potential for actual harm. There is a history related to this area of non-compliance: August 23, 2016, VPC; September 14, 2015, VPC; April 30, 2014, CO.
(523)

Ontario

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

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

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

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

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Dec 30, 2016

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

**Issued on this 20th day of October, 2016**

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

**Name of Inspector /**
**Nom de l'inspecteur :** DEBORA SAVILLE

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