Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 16, 2018	2018_718604_0002	002218-18	Resident Quality Inspection

Licensee/Titulaire de permis

ATK Care Inc.
1386 Indian Grove MISSISSAUGA ON L5H 2S6

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

River Glen Haven Nursing Home
160 High Street P.O. Box 368 Sutton West ON L0E 1R0

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

SHIHANA RUMZI (604), CECILIA FULTON (618), DIANE BROWN (110), GORDANA KRSTEVSKA (600)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 29, 30, 31, February 1, 2, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 20, 22, 23, 26, 27, March 21, 22, 23, 26, 27, 28, and 29, 2018.

The following Critical Incident System (CIS) report intakes related to alleged abuse and neglect in the home were completed during this inspection:
Log #024765-17
Log #027778-17

Log #028339-17
Log #022851-17
Log #028337-17, and Log #023065-17
Log #023980-17
Log #005065-18
Log #005451-18

The following intakes related to falls:
Log #020222-17
Log #029516-17
Log #001248-18
Log #001247-18
Log #006009-18

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (Acting DOC), Associate Director of Care (Acting DOC), Environmental Services Manager (ESM), Director of Support Services (DSS), Registered Dietitian (RD), Office/Administrative Manager (OAM), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Recreation Aide (RA), Gem Agency PSW's, Staff Relief PSW's, Housekeeping, Behaviour Support Services Lead (BSS), Dietary Aide (DA), Cook, Physiotherapy Assistant (PT), Student Volunteer (SV), Residents, Substitute Decision Makers (SDMs), Presidents of the Residents' and Family Council.

During the course of the inspection, the inspectors conducted a tour of the home, made observations of: medication administration and storage area, staff and resident interactions, provision of care, conducted reviews of health records, and critical incident log, staff training records, meeting minutes of Residents' and Family Council meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Family Council
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

During the course of this inspection, Non-Compliances were issued.
- **19 WN(s)**
- **12 VPC(s)**
- **2 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 #005	2017_370649_0014	604
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #002	2017_370649_0014	604
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #003	2017_370649_0014	604
O.Reg 79/10 s. 31. (3)	CO #006	2017_370649_0014	618
O.Reg 79/10 s. 49. (2)	CO #004	2017_370649_0014	618
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_370649_0014	110

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee had failed to protect residents from abuse by anyone.

On an identified date the home contacted the Ministry of Health and Long Term Care (MOHLTC) After Hours Pager, and reported abuse occurred between resident #065 and #066, in an identified location of the home at an identified time. On an identified date, the home also submitted a Critical Incident System (CIS) report, which indicated the Housekeeper (HSK) #167 had witnessed the incident when they had arrived on the floor and an incident occurred between resident #066 and #065. Resident #065 was assessed by the registered staff and was transferred to hospital for further assessment. Resident #065 sustained injuries.

An interview was conducted with HK #167 who confirmed to have witnessed the incident. The HK stated during the time of the incident it was shift change and the identified floor was in an identified area.

A review of resident #066’s clinical records was carried out for an identified period of time, identified the resident to be ambulatory with identified responsive behaviours.

Interviews were conducted with Personal Support Worker (PSW) #164 and PSW #165 on two separate identified dates. The PSW staff indicated they work on an identified floor which consisted of residents who present with responsive behaviours. The PSW's stated that resident #066 will present with identified responsive behaviours when the home area is in an identified state.

During interviews with Registered Practical Nurse (RPN) #121 and #131, on an identified date, the RPN staff indicated they worked on the identified floor and knew resident #066 who presented with identified responsive behaviors.

In an interview with the Acting Director of Care (DOC) #101, indicated that they were aware of the incident which occurred on an identified date, and a CIS report was submitted to the MOHLTC Director. The Acting DOC indicated resident #066 resided on an identified floor of the home and that the resident had responsive behaviours. The Acting DOC reviewed the written plan of care for resident #066 and identified that a known trigger had not been captured for resident #066's responsive behaviours resulting in identified responsive behaviors. The Acting DOC further stated that there were no identified interventions or direction in the written plan of care to staff related to the prevention of escalating behaviours of resident #066 when the floor is in an identified state.

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee had failed to ensure that the written plan of care sets out clear directions to staff and others who provided direct care to the resident.

This inspection was initiated due to observations made while completing the medication administration observation. Observation of the medication administration pass for resident #022 was conducted on an identified date, time and floor of the home.

The inspector requested the Acting DOC accompany the inspector to review some of the issues identified in the inspector's initial observation. The inspector and Acting DOC made this observation on an identified date.

During the observation the inspector and Acting DOC identified that resident #022 had an identified method of medication administration. The three identified medication administration sites had identified dates for when they were applied.

Interviews with RPN #112 and Acting DOC revealed that the three identified medication administration sites are to be identified with the date and use, as described above and

that they are to be changed as indicated.

A review was carried out for an identified date on the Electronic Medication Administration Record (E-MAR) which contained only one measure pertaining to the three identified medication administration methods. Nursing Measure -Change identified medication administration methods as directed. This item was signed off on four identified dates of an identified month in 2018. A review of the E-MAR revealed that only one identified medication administration method was included and that there was no direction provided for the other areas.

An interview with RPN #112 indicated they were going to change the identified medication administration sites and when asked how they knew the changes were due, they stated they saw the date on the the identified area.

An interview with the Acting DOC confirmed that all identified medication administration sites should have been included in the E-MAR to provide clear direction to staff.

2. The licensee had failed to ensure that there was a written plan of care for the resident that set out the planned care for the resident.

The home submitted CIS report on an identified date to the MOHLTC. The CIS report indicated resident #010 was identified as having an identified diagnosis and treatment was not provided.

A review of the admission progress notes for an identified date was documented by RPN #121 revealed that resident #010's Substitute Decision Maker (SDM) informed the RPN that they suspected an identified health condition. The progress note included documentation that identified interventions were required and review of the resident's progress notes on an identified shift for an identified date, indicated staff were unable to follow the set intervention. Further review of the progress notes for five identified dates in an identified month in 2017, did not include any indication of the identified intervention being carried out when a progress note, carried out by RPN #120 documented that orders were received from physician #172 for to carry out an identified process as per family's request and that the care was provided.

An interview with RPN's #121 and #120, revealed that shift to shift communication related to resident's health status is captured in each resident's progress notes and the progress notes are printed and used as a report for the next shift. RPN #120 revealed the

oncoming shift would use those printed progress notes to inform them about resident care issues that were occurring or ongoing and would require follow up on their shift. A review of resident #010's progress notes was carried out with the RPN who confirmed that there were no progress notes related to the set interventions for resident #010 till an identified date. RPN #120 revealed that without any documentation about this issue in the progress notes, staff would not know that it was a part of the residents' plan of care.

An interview with the Acting DOC confirmed that the report method described by RPN #120 is the current home practice and revealed that not documenting the planned care for the resident on one shift may result in the planned care not being passed on and potentially lost.

A review of the progress note made by RPN #120 on an identified, indicated they had not been able to carry out the identified order. An interview with RPN #120 revealed that on an identified date, they became aware that the order had not been carried out however, once the issue was identified the physician on duty wrote the order and the care was provided to the resident. RPN #121 identified that on an identified date, resident was experiencing identified symptoms and had reviewed the resident's records to discover that no prescription had been written to treat the previously identified health condition. The resident was transferred to the hospital for treatment and was diagnosed with an identified health condition.

Record review revealed that resident #010's physician reviewed the resident's documentation on an identified date, and confirmed the health condition.

An interview with physician #173 indicated they intended to write an order for treatment for resident #010's identified health condition but did not do so and acknowledged that planned care for the resident had not been documented.

On an identified date, RPN #121 identified that the resident indicated that they were not feeling well. The resident was transferred to the hospital for treatment and had an identified diagnoses.

An interview with the Acting DOC confirmed that the written plan of care for resident #010, did not include the planned care for the resident with respect to the assessment and treatment of an identified health condition.

3. The licensee has failed to ensure that there was a written plan of care for each

resident sets out clear directions to staff and others who provide direct care to the resident.

The home submitted a CIS report on an identified date, to the MOHLTC Director related to a fall which resulted in injury to resident #036 for which the resident was transferred to hospital and resulted in a significant change in the resident's health status. The CIS report further stated resident #036, was being provided care by PSW #115 and was transferred from one position to another with an identified ambulation device. The resident fell, sustained injury, and was transferred to the hospital, and returned to the home with identified diagnosis.

A review of resident #036's written plan of care for an identified date, for transfer indicated staff are to provide extensive assistance by one staff to offer weight bearing support. The written plan of care further directed the staff to follow step by step directions. Further review of resident's written plan of care did not provide direction to the staff as to how to transfer the resident from standing position back to bed.

An interview with resident #036 revealed that on an identified date, on return from an identified location of the home with one staff assistance the resident sustained a fall.

An interview with the Physiotherapist (PT) #124 revealed resident #036 needed extensive weight bearing assistance for transfers.

An interview with PSW #115 revealed they assisted resident #036 to transfer from one area to another as indicated in the plan of care. The PSW confirmed that they transferred the resident the same way all the time, because there is no other intervention in the plan of care to guide the staff how to transfer the resident from one position to another.

An interview with PSW #104 also confirmed there was no specific guidelines for the staff as to how to assist the resident to transfer from one position to another.

An interview with the Acting DOC confirmed the written plan of care did not specify how the resident was to be assisted with transfer's one position to another.

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

The home submitted a CIS report on an identified date, to the MOHLTC Director related

to a fall which resulted in an incident causing injury to resident #036 for which the resident was transferred to hospital and resulted in a significant change in the resident's health status. The CIS report further stated resident #036, was being provided care by PSW #115 and was transferred from one position to another with an identified ambulation device. The resident fell, sustained injury, and was transferred to the hospital and returned to the home with identified diagnosis.

A review of resident #036's Risk Management record on an identified dated, revealed the resident was not able to turn around at an identified location do to the lack of space. During the transfer, the resident's leg buckled and they fell backwards on to the floor.

A review of resident's Minimum Data Set (MDS) assessment on an identified dated, revealed that the resident had an identified range of motion.

A review of resident #036's written plan of care revealed that resident #036 was identified to be at risk for falls due to their history of falls, and identified limitations. The goal was to have no injury from falls, and one of the interventions was staff to ensure environment was free of clutter.

An interview with resident #036 confirmed that they had fallen because there was not enough room to turn around and sit.

5. The home submitted a CIS report on an identified date, to the MOHLTC Director, related to an incident which caused an injury to the resident for which the resident was transferred to a hospital for further assessment. The CIS further stated that the resident attempted to self-transfer in an identified location of the home fell and sustained injuries. The resident was transferred to hospital and returned that day with injuries.

During an observation carried out on an identified date for resident #038, the inspector found the resident in an identified location of the home in a sliding posture, and not properly positioned. The inspector brought this to the attention of PSW #126.

An interview was carried out with PSW #126 on an identified date. The PSW indicated they had transferred resident #038 that day, and confirmed that they transferred the resident using a pivot technique and indicated that they carried out the transfer alone but needed two staff for transfers.

A review of the post fall assessment records carried out on an identified date for resident

#038 indicated that one of the contributing factors of falls for the resident was that poor positioning.

A review of resident #038's MDS assessment carried out for an identified dated revealed that the resident was to be transferred manually with extensive assistance by two staff.

A review of resident #038's written plan of care for an identified period, indicated under the fall focus that the resident is to be transferred manually with extensive assistance by two staff and the resident utilized an identified ambulation device on and off the unit and staff are to transfer the resident.

An interview was carried out with Registered Nurse (RN) #125 on an identified date. The RN stated PSW staff are not to transfer residents alone. The RN further stated a second staff is required to properly position the resident when in the mobility device. The RN stated PSW #126 should have followed resident #038's written plan of care related to transfers and should have gotten assistance from another PSW for the transfer.

An interview with the home's Administrator was carried out on an identified date. The Administrator stated all staff are expected to follow each resident's written plan of care and the registered staff working on the floor are expected to ensure PSW staff are aware of each resident's written plan of care and provide care as specified in the plan.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee had failed to ensure that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was fully respected and promoted.

The home submitted a CIS report on an identified date to the MOHLTC Director, indicating resident #039's SDM reported to the home that the resident was not assisted when they asked for assistance from a PSW and was left uncared for in an identified location of the home.

An interview with resident #039, revealed that on an identified date, when PSW #156, came to take the resident to an identified location of the home, the resident asked the PSW to for assistance related to care. The PSW told the resident that they were behind with their tasks, transfered the resident to an identified location of the home, and told the resident they would provide care to the resident after an identified time. The resident further stated as their care needs where not met.

A review of resident #039's identified assessment assessment on an identified date, revealed the resident preference was be provided assistance in a washroom and needed to be assisted by the staff.

A review of resident #039's written plan of care revealed that the resident was identified to require staff assistance due to identified mobility challenges and received identified medication. Staff were directed to ensure the resident was provided with assistance to and from the toilet, was provided with an identified product and the product to be

monitored by staff at identified times.

An interview with PSW #156, could not verify that they provided care to resident #039, on an identified date. The PSW confirmed that the resident did require care when they received the resident.

An interview with RN #136 verified that the PSW staff are expected to follow the resident's written plan of care, and also for residents who request assistance, the PSW's are expected to assist the resident so the resident was properly cared for in a manner consistent with the resident's needs.

Interview with Acting DOC confirmed the resident's right to be properly cared for in a manner consistent with their needs had not been respected and promoted.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was fully respected and promoted, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee had failed to ensure that the home was a safe and secure environment for its residents.

The home submitted a CIS report on an identified date, to the MOHLTC Director related to a fall which resulted in an injury to a resident for which the resident was sent to the hospital which resulted in a significant change in the resident's health status.

A review of resident #045's progress notes for an identified date indicated RPN #120 entered an identified location of the home and found resident #045 on the floor and PSW #150 was beside the resident. PSW #150 told the RPN they believed resident attempted to lean on an identified area which gave way and the resident fell. After the resident was assessed and injury identified, the resident was transferred to the hospital for further assessment. The resident returned to the home from hospital on with an identified diagnosis.

A review of resident #045's MDS assessment for an identified dated, prior the incident, revealed that resident #045 was admitted to the home with identified diagnosis and needed supervision by one staff for walking.

Observation of an identified area of the home was carried out and revealed that all the identified areas of the home consisted of a curtain placed next to the door entrance.

An interview with PSW #150 indicated that the curtain in an identified area of the home was pulled across and the resident may have leaned on it. The PSW indicated the PSW who provided the care earlier to the resident, should have pulled the curtain all the way back to the wall.

Interview with RPN #105 acknowledged that the curtains in an identified location of the can pose a safety risk for residents if they are not kept pulled all the way back to the wall.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home was a safe and secure environment for its residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee had failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any mood and behaviour patterns, any identified responsive behaviours, and any potential behavioural triggers and variations in resident functioning at different times of the day.

On an identified date, the home contacted the MOHLTC After Hours Pager and reported that abuse had occurred between resident #065 and #066, in the an identified location of the home at an identified time. On an identified date the home also submitted a CIS report, which indicated the Housekeeper (HSK) #167 had witnessed the incident when they had arrived on floor. Resident #065 was assessed by the registered staff and was transferred to hospital for further assessment. Resident #065 sustained injuries which required further care.

A review of resident #066's electronic progress notes was carried out for an identified period of time which indicated the identified responsive behaviours.

A review of resident #066's written plan of care with an identified print date, and the kardex with an identified print date did not identify an identified trigger or focus for the

resident.

Interviews were conducted with PSW #164 and PSW # 165 separately on identified dates. The PSW staff indicated they worked on an identified floor which consisted of residents who present with responsive behaviours. The staff stated that they are able to review the kardex and plan of care for the residents on the related to their Activities of Daily Living (ADL)’s and responsive behaviours which is accessible on their Point of Care (POC) tablets. The PSW's stated that identified situations were a trigger for resident #066 which they were aware of and identified the resident had presented with identified responsive behaviours due to the identified situation on the floor.

Interviews were conducted with RPN #121 and #131, on an identified date, the RPN staff indicated they worked on an identified floor and know resident #066 who presented with identified responsive behaviors. The RPN’s stated resident #066 presents with identified responsive behaviors and indicated there was a known trigger for the resident’s responsive behavior. The RPN's further indicated that the plan of care for resident #066 had not included an assessment of the resident related to their responsive behaviour related to an identified trigger.

The written plan of care and the kardex was reviewed for resident #066 by PSW # 164 and PSW # 165, RPN #121 and #131. The four staff reviewed the written plan of care and kardex acknowledged that an identified trigger was not captured as a trigger or focus for resident #066. The staff stated the identified trigger should have been an identified trigger and included in the resident's plan of care.

An interview with the Acting DOC #101 indicated resident #066 resided on the on identified floor of the home and floor consisted of residents with responsive behaviours. The Acting DOC reviewed the PCC progress notes for resident #066 related to the identified trigger and confirmed that resident #066's plan of care did not reflect an identified trigger for their responsive behaviour.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any mood and behaviour patterns, any identified responsive behaviours, and any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(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 :

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

Resident #002 was triggered from stage one of the Resident Quality Inspection (RQI) for an identified alteration in skin.

A review of resident #002's PCC identified assessment indicated the alteration in skin was initially identified on an identified date. The assessment indicated the characteristics of the alteration in skin. Further review of the weekly assessments revealed no assessments were carried out for an identified period of time.

The inspector reviewed resident #002's PCC progress notes and did not find evidence of any assessments related to alteration of skin being documented for an identified period of time.

Interviews were conducted with RPN #112 and #120, on an identified date. The RPN's stated when a resident is identified with an alteration in skin integrity, an assessment is to be carried out weekly and documented in the assessments tab on PCC under the assessment tab. The RPN's indicated resident #002 had an identified alteration in skin which was first identified on an identified date, and required weekly assessments until healed. The RPN's reviewed the residents PCC assessments tab and acknowledged that there was identified assessments carried out for an identified period of time. The RPN's confirmed that the resident's identified assessments had not been carried out for an identified period of time.

An interview conducted with the home's Acting DOC indicated the nursing staff are to carry out an identified assessment on PCC assessment tab when an alteration of skin is identified and an identified assessment is to be carried out weekly until the site has healed. The Acting DOC reviewed resident #002's identified assessments and acknowledged that a weekly identified assessment was not carried out for the dates indicated above.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee had failed to ensure that for each resident demonstrating responsive behaviours actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

On an identified date, the home contacted the MOHLTC After Hours Pager and reported that abuse had occurred between resident #065 and #066, in the an identified location of the home at an identified time. On an identified ate the home also submitted a CIS report, which indicated the Housekeeper (HSK) #167 had witnessed the incident when they had arrived on floor. Resident #065 was assessed by registered staff and was transferred to hospital for further assessment. Resident #065 sustained injury.

The home's policy "Responsive Behavioral Management Program Referral Process", Index I.D.: RCSM G-45-05, stated under procedure number eight that the Behavioral Support Resource Team (BSRT) will review each referral on a daily basis.

A review of resident #065's quarterly MDS assessment on an identified dated under section E for mood and behaviors pattern, section four for behavioral symptoms indicated the resident presented with identified responsive behaviors which occurred during an identified period of time, and the identified responsive behavior was not easily altered.

A review of resident #065's clinical records indicated that on an identified date, a "Responsive Behavior Referral" was completed that indicated the resident presented with an identified responsive behaviour for an identified period of time. The referral indicated that this was a new responsive behaviour and that when staff re-approached the resident and offered care when they where not successful. Another "Responsive Behavior Referral" was submitted on an identified date, which indicated that identified responsive behaviours towards co-resident which was a worsening behavior, and staff separated the residents and resident settled. There was no Responsive Behavior Follow Up found for the two Responsive Behavior referrals submitted as the sections where highlighted in white and had no documentation.

Interviews conducted with RPN # 121, and RPN #131, on an identified date. The RPN's indicated the home has a Behavioral Support Lead (BSL) who addresses and assists staff with any responsive behaviors identified on the unit. The RPN's stated they complete a "Responsive Behavior Referral" on PCC under the "Assessments" tab when a new or worsening responsive behavior is identified for a resident. The RPN's confirmed the two "Responsive Behavior Referrals" where sent on identified dates had been sent and had not been followed up by the BSL for resident #065, on PCC. The RPN's stated the Responsive Behavior Referral was to be reviewed and be followed up by the home's BSL #166.

An interview with the BSL #166 was carried out on an identified date. The BSL stated they receive "Responsive Behavior Referrals" for residents presenting with responsive behaviors so that the resident can be assessed and interventions put in place to address responsive behaviors. The BSL indicated they are to review the "Responsive Behavior Referrals" on a daily basis and assist with assessment and interventions for the resident. The BSL reviewed resident #065's PCC "Assessment" tab and "Responsive Behavior Referrals" and acknowledged receipt of the referrals and that the resident was not

assessed as they were absent from the home.

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 ensure that for each resident demonstrating responsive behaviours actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

The licensee had failed to ensure that an individualized menu was developed for the resident if their needs cannot be met through the home's menu cycle.

A record review of resident #058's written plan of care for an identified date, indicated a list of food restrictions for the resident.

A record review for an identified date was carried out of the progress note done by the Registered Dietitian (RD) identified that resident #058 remained at an identified risk related to their health status, and further identified that they would refer to the MD regarding lab levels. The RD's plan included the implementation of an identified intervention.

A review of the food production systems identified a binder containing sheets of paper including one with resident #058's name. The sheet identified resident #058's restriction.

On an identified date and time, an interview was conducted with the Cook/Dietary Aide (CDA) #143. Staff confirmed that there was no menu available but that they prepared identified substitutions when necessary.

A record review of the menu was carried out for an identified date and an identified menu was planned. Inspector questioned CDA #143 if this menu item was suitable for an identified diet. Staff revealed there was no direction not to serve the menu item. A review of the ingredients on the identified product labelled an identified food as the first ingredient. Staff #143 confirmed that an identified food was included in the list of foods to be avoided and an identified food item should not be served. Further menu review identified that on an identified date another meal was identified to be avoided which were identified to be avoided for resident #058. No menu alternative was identified.

On an identified date and time, an interview was carried out with Dietary Aide (DA) #142 who identified that staff serving would not know of suitable substitution to be served as serving staff do not know ingredients.

On an identified date and time an interview was held with the Director of Support Service (DSS) #145. When asked how staff are directed on what foods to replace the identified food restriction from the meal, the DSS stated there should be a menu. The DSS confirmed there was no menu in place for residents with a diet requiring the identified restriction.

A record review of resident #057's progress notes identified that on an identified date, a physician note identified resident's identified date. The resident's plan of care on an identified date, identified that resident #057 continued to follow an identified diet. A review of the food production systems identified a sheet of paper with resident #057's name and diet. The sheet identified the dietary restrictions and a list of foods to avoid was identified. An individualized menu was not available.

A record review of resident #056's plan of care identified that resident #056 was as an identified risk related to in part, what was documented as a change in lab value level which was normalized with dietary interventions. A review of the food production systems identified a sheet of paper with residents name and diet of regular with specific food restrictions. The sheet identified the dietary restriction and a list of foods to avoid was identified. An individualized menu was not available.

Interview with the RD #144 confirmed that resident #058, #056, and #057, were on an

identified restricted diet. The RD further acknowledged that residents with the identified restriction may not meet their nutrient need from the regular menu. The RD was unsure if a specific food was suitable on an identified restricted diet as it depended on what was in the product. The RD stated that in the past they did prepare menus and check product packages but that they currently do not have time to create a menu and that there were no menus in place.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an individualized menu was developed for the resident if their needs cannot be met through the home's menu cycle, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s.101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).

Findings/Faits saillants :

The licensee had failed to comply with the following requirements of the LTCHA: it is condition of every licensee that the licensee shall comply with every order made under this Act.

On an identified date, the compliance order (CO) #006, made under O. Reg. 79/10 r. 31. (3), was served:

The licensee must be compliant with O. Reg. 79/10 r. 31. (3).

Specifically, order number #006. With an identified compliance date, directed the licensee to:

1. Develop a documented monitoring system to ensure that all residents within the home receive at a minimum two baths/showers twice a week by method of his/her choice.

In an interview with the Acting DOC and Administrator confirm that they had not developed the above required monitoring system as indicated in the order.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that they have complied with every order or agreement entered into under this act, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (3) The quarterly evaluation of the medication management system must include at least,
(a) reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk; O. Reg. 79/10, s. 115 (3).
(b) reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act; and O. Reg. 79/10, s. 115 (3).
(c) identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 115 (3).

Findings/Faits saillants :

The licensee had failed to ensure that a quarterly evaluation of the medication management system included a review of the reports of any medication incidents.

A review of the Supplementary Medication Management Process Review which reviewed Quarter three identified months in 2017, did not include a review of all of the medication incidents that had occurred in that quarter.

In an interview with the Acting DOC revealed that it is the RN's duty to fax the medication incident reports to the pharmacy and this process had not occurred. As a result, the pharmacy, who lead the quarterly discussions and review of the medication incidents were not aware of all of the medication incidents that had occurred in the home for the quarter identified above. The Acting DOC confirmed that the quarterly medication incident review had not occurred.

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 ensure that the quarterly evaluation of the medication management system included a review of reports of any medication incidents, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

The licensee had failed to ensure that drugs remained in their original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

On an identified date and time, the inspector conducting a medication administration observation on an identified location of the home with RPN #112 for resident #022 which included the delivery of multiple identified medications.

The inspector observed RPN #112 check the E-MAR of the resident and was observed to remove a container containing fluid from the resident's medication drawer and put it on top of the medication cart in preparation for administration. The inspector questioned the RPN as to what was in the container. The RPN replied that is was an identified medication that they had prepared earlier that day and left it in resident #022's drawer. The inspector asked the RPN if it was their usual practice, to which they replied yes.

The inspector observed that the container was not labelled and the RPN confirmed that it was not labelled as the home did not have labels for this purpose. The RPN was then observed to remove the container out of the top drawer of the medication cart from an unlocked area. They checked the medication and the E-MAR and took out the required

dose of the medication the RPN was then observed entering resident #022's room. The RPN administered the multiple identified medication in the identified areas and after the medication administration the inspector asked the RPN to show them where these medications had been stored and the RPN opened the top drawer of the medication cart. The Inspector observed a paper medication cup which contained the container containing an identified medication and an open/broken glass container of an identified medication.

RPN #112 indicated to the inspector that they had opened the container on an identified shift and prepared the medications which were scheduled to be administered on their shift. RPN #112 confirmed that it was the container which consisted of an identified medication and was administered to the resident. RPN #112 revealed that they would keep that opened container there until they would dispose of it with another registered staff. The Inspector asked the RPN if the identified container was a multi-use container and the RPN stated that they were doing what they had been previously told to do.

Following this observation and discussion, the Inspector brought the Acting DOC to the unit to review the Inspectors observations and interview with the RPN. The Inspector and the Acting DOC observed the situation as described above, with the open containers of the identified medication sitting in a medication cup of the top unlocked drawer. The DOC confirmed that this is not proper practice or proper storage of identified medications. The Acting DOC, RPN #112 and the Inspector discussed the RPN's practice of preparing medication in advance of administration and the Acting DOC confirmed that this practice is not compliant.

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 ensure that drugs remained in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

The licensee had failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies.

The inspector carried out a medication storage area observation on an identified date and time and on an identified location of the home, with RPN #121.

Several non-medication items were observed to be stored in the cart, including resident's glasses, glasses cases, wallet, money, hearing aid and resident identification.

An interview with RPN #121 confirmed the above listed items were in the medication cart and that this was usual practice as there is no other secure area to store resident items.

2. The licensee had failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard, in the locked area or stored in a separate locked area within the locked medication cart.

On an identified date and time the inspector conducted a medication administration observation for resident #022 on an identified date with RPN #112 which included the delivery of identified medications. The RPN was observed to remove the identified medications from the top, unlocked drawer of the medication cart when preparing these medications for administration. Closer observation revealed that these medications were sitting inside a paper medication cup in the top drawer of the medication cart.

Interview with RPN #112 revealed that this was their usual practice.

Following this observation and discussion, the inspector brought the Acting DOC to the unit to review their observations during the medication administration with RPN #112.

The inspector and the Acting DOC observed these medications as described above.

Interview with the Acting DOC confirmed that the drawer where these medications were located was not double locked as required and that it was not a proper storage of Narcotics and Controlled substances and the medication was to be double locked in the narcotic bin of the medication cart.

Additional Required Actions:

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

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

The licensee had failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, and the resident's SDM.

Review of the home's Medication Incident Report, for an identified date, for resident #011, revealed that resident #011 had not received their prescribed medication on an identified date. A review of the medication incident report did not indicate that the resident's SDM of the resident had been informed of this medication error.

Interview with the Acting DOC confirmed that the SDM had not been notified regarding this medication incident and also revealed that it is the responsibility of the RN's to notify the SDM in the event of a medication error, and acknowledged that this communication had not occurred when resident #011 had an incident of missed medication.

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 ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, to be implemented voluntarily.

WN #14: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
2. Residents must be offered immunization against influenza at the appropriate time each year. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

The licensee has failed to ensure that residents were offered immunization against influenza at the appropriate time each year.

The MOHLTC received a complaint through the ACTIONline on an identified date, from complainant #108. The complainant stated they were informed by a home's staff member that the home did not offer all the residents immunization against influenza until one week after an idenified outbreak. The complainant further indicated that the home did not have sufficient supply of the vaccine.

On an identified date, the inspector conducted interviews with resident #006, #009, #025, and #026, the residents confirmed that they were not offered immunization against influenza.

On an identified date, the inspector conducted telephone interviews with SDM #128, of resident #024, and SDM #129, for resident #027. Both SDM's acknowledged they had not been contacted for 2017, in relation to the immunization for their family members who reside at River Glen.

A review of the home's immunization against influenza administration record indicated 74 out of 119 residents were not offered immunization against influenza. for 2017.

An interview conducted on identified date and time with the Acting DOC indicated the home offers the immunization against influenza to all residents. The Acting DOC acknowledged 74 residents were not offered immunization against influenza at the appropriate time each year.

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 ensure that residents were offered immunization against influenza at the appropriate time each year, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

The licensee had failed to ensure that all elevators in the home are equipped to restrict resident access to areas that were not to be assessed by residents.

This inspection was initiated on an identified date, Inspector #618 observed a resident alone in an identified location of the home.

The inspector heard staff speaking to a resident in an identified location of the home and upon closer observation the resident was identified as resident #018, and the staff was HSK #122. The HSK was observed talking to the resident who was in an identified location of the home and asking the resident where they were going and the HSK returned the resident to their home area.

Inspector #618 followed up and observed resident in an identified location of the home and attempts to communicate with the resident were not successful.

An interview was conducted with HSK #122 revealed that they were in an identified location of the home and resident #018 was alone. The HSK revealed that they knew this resident and that the resident was quite confused and did not know where they were or where they were going.

A short time after the incident, the inspector observed resident #019 was in an identified location of the home alone. The resident appeared confused and said something about going to another identified location of the home. A food service worker who was there when this event occurred said that they would bring the resident to the identified area of the home. The inspector also went and when we arrived the identified location of the home was closed and the resident said something about getting the appointment mixed up.

Interview with PSW #123 revealed that resident #019 is very confused and is not safe to be alone or going alone to an identified location of the home.

Interview with the Administrator #100 confirmed that the identified location of the home is not considered a residential area and that when resident's access the area they should be accompanied by a staff member.

The Administrator further revealed that there is no lock mechanism to restrict access to the access to the identified are from the floors.

WN #16: 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. (3) Every licensee shall ensure that the policy to promote zero tolerance of abuse and neglect of residents is communicated to all staff, residents and residents' substitute decision-makers. 2007, c. 8, s. 20 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was communicated to all staff.

The home submitted a CIS report on an identified date to the MOHLTC Director related to alleged abuse by agency PSW #162 towards resident #064. The CIS stated RN #125 observed agency PSW #162 and the home’s staff member #163 arguing in the hallway outside an identified room. The staff #163indicated to the RN that they observed the agency PSW act inappropriately toward resident #064 that they intervened and immediately confronted the PSW of their observations. The RN assessed the resident and no injury was found.

The home’s policy “General Employee Orientation”, Index id: HRM B-05, dated February 2018, under procedure number two stated that employment of all individuals commence with a general orientation day. Where this is not possible the department head or designate will be responsible to review, the new employee, some essential components of the general orientation such as: confidentiality, Residents Bill of Rights, Abuse policy and infection control. The new employee will be scheduled for the next orientation day. The date of the general orientation will be set by the educator in conjunction with department heads and based on demand. (Note: agency staff will review the Agency Orientation Binder and complete Orientation Checklist on the first day of service).

On an identified date, the inspector reviewed the home’s “Agency Orientation Binder”, and the “Nursing Agency Orientation Checklist”, located at the first floor nursing station. Upon review of the binder the last “Nursing Agency Orientation Checklist” was on an identified date, no “Nursing Agency Orientation Checklist” was found for the date of the incident, for agency PSW #162.

An interview was carried out with the Acting DOC who acknowledged that a “Nursing Agency Orientation Checklist” was not carried out on the date of the incident, for agency PSW #162, as the RN on an identified shift was also an agency RN. The Acting DOC confirmed the home's abuse and neglect policy had not been communicated to agency PSW #162 prior to starting on the floor.

WN #17: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

The licensee had failed to ensure that the results of an abuse investigation was reported to the Director.

The home contacted the MOHLTC After Hours Pager, related to alleged abuse by agency PSW #162 towards resident #064. The home submitted a CIS report on an identified date to the MOHLTC Director related to alleged abuse by agency PSW #162 towards resident #064. The CIS report stated RN #125 observed agency PSW #162 and the home's staff member #163 arguing in an identified location of the home. The staff #163 indicated to the RN that they observed the agency PSW act inappropriately towards resident #064.The RN assessed the resident and no injury was found.

A review of the CIS report indicated the home was caring out an investigation to the incident indicated above. A review of the home's CIS report binder along with investigation notes showed evidence of an investigation conducted by the home and the home concluded that abuse had occurred from agency PSW #162 to resident #064.

An interview was carried out with the Acting DOC who indicated that they did investigate the above alleged abuse which occurred between agency PSW #162 and resident #064. The Acting DOC stated after the conclusion of the home's investigation the home determined that abuse did occur as staff #163 witnessed the incident and the agency PSW was relieved from their duties with resident #064. The Acting DOC acknowledged that the CIS report submitted on an identified date, was not amended to show the results of the home's abuse investigation and it was not reported to the Director.

WN #18: 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 :

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

The home submitted a CIS report on an identified date to the MOHLTC Director, related to a fall which caused injury to resident #036 for which the resident was taken to the hospital and which resulted in a significant change in the resident's health status.

A review of resident #036's health record indicated the resident had been identified to be at risk for falls due to history of falls and other identified factors. Further review of resident #036's progress notes for an identified date revealed that the resident had a fall on the same date and complained of pain. The team decided to de-clutter the area where the resident fell so that the resident would be able to mobilize with ease.

Review of resident #036's post fall assessment indicated no post fall assessment was completed for the fall on an identified date.

An interview with RPN #105 indicated resident #036 had been assessed at the time of the fall and the information was entered in a section titled "Risk Management" located in PCC. The RPN confirmed that they do not use any other tool for conducting a post fall assessment.

The home's policy "Falls Prevention and Management", Index ID RCSM G-40, dated October 31, 2017, stated under the procedure that all residents will be assessed post falls to determine extent and types of injury, to assess contributing factors, that may have

caused the fall and to identify preventative fall intervention strategies. The procedure also stated registered staff was to complete the post fall assessment section in the “Risk Management” tab, under the “Action” tab under the “Triggers UDAs" header.

A review of the “Risk Management” report revealed under the “Action” tab in the “Risk Management” section was not completed therefore the program was not able to produce a post fall assessment record.

An interview with the Acting DOC confirmed that prior to the RQI in 2017, the home had utilized the progress notes titled "Post Fall Notes", to document a residents condition after a fall. The Acting DOC verified that they became aware that the tool they were using was not a clinically appropriate assessment instrument identified by the RQI report from 2017. Since the last RQI the home had utilized the post fall assessment instrument in the “Risk Management” section that populate in the assessment tab as "Post fall assessment", a clinically appropriate assessment instrument.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

The licensee has failed to ensure that where an incident had occurred that caused an injury to a resident for which the resident was taken to a hospital, and the injury had resulted in a significant change in the resident's health condition to inform the Director of the incident no later than three business days after the occurrence of the incident.

The home submitted a CIS report on an identified date to the MOHLTC Director

regarding resident #045, who had an incident that caused an injury resulting in a hospitalization and in a significant changes in resident's condition.

A review of resident #045's health record revealed the resident had an incident on an identified date, sustained an injury and was sent to the hospital for treatment. The resident returned from the hospital with an identified injury and change in their physical condition.

A review of the home's compliance binder revealed that the home submitted a CIS report to the MOHLTC Director related to resident #045's injury 64 days after the incident.

Interview with the Acting DOC verified that they were not aware what happened at the time of the incident and had not reported to the Director according to the regulation and they confirmed that the MOHLTC Director was not informed within the three business day after the occurrence of the incident.

2. The licensee had failed to ensure that the licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, to make a report in writing to the Director setting out the actions taken in response to the incident, including the outcome or current status of the individual or individuals who were involved in the incident.

The home submitted a CIS report on an identified date to the MOHLTC Director related to an incident between resident #043 and #044. Resident #043 was injured and transferred to hospital for further assessment. The injury resulted in resident #043 being transferred to hospital.

An interview with the Associate Director of Care (ADOC) #132 stated resident #044 and resident #043 resided in an identified location of the home and on an identified date, the resident #044 went to an identified location of the home to find resident #043 in an identified location of the home. The ADOC indicated the home conducted an in-depth investigation considering resident #044 statement and concluded there was no indication that abuse happened in this incident. The ADOC confirmed that the home did not notified the Director of the outcome of the investigation and the current status of the individuals who were involved in the incident.

Issued on this 27th day of July, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHIHANA RUMZI (604), CECILIA FULTON (618), DIANE BROWN (110), GORDANA KRSTEVSKA (600)
Inspection No. / No de l'inspection :	2018_718604_0002
Log No. / No de registre :	002218-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 16, 2018
Licensee / Titulaire de permis :	ATK Care Inc. 1386 Indian Grove, MISSISSAUGA, ON, L5H-2S6
LTC Home / Foyer de SLD :	River Glen Haven Nursing Home 160 High Street, P.O. Box 368, Sutton West, ON, L0E-1R0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Karen Ryan

To ATK Care Inc., 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 must be compliant with s. 19. (1) of the LTCHA.

The licensee shall prepare, submit and implement a plan for achieving compliance with the requirement under the LTCHA. Specifically, the plan must include:
a) The development and implementation of strategies to minimize the risk of triggering an identified responsive behaviour in residents with a known identified trigger.

b) The plan must also include interventions to manage/minimize risk of resident to resident negative interactions during shift change.

Please submit the written plan for achieving compliance for inspection #2018_718604_0002, to Shihana Rumzi, LTC Homes Inspector, MOHLTC, by email to MOHLTCIBCentralE@ontario.ca, by July 23, 2018.

Grounds / Motifs :

1. The licensee had failed to protect residents from abuse by anyone.

On an identified date the home contacted the Ministry of Health and Long Term Care (MOHLTC) After Hours Pager, and reported abuse occurred between resident #065 and #066, in an identified location of the home at an identified time. On an identified date, the home also submitted a Critical Incident System (CIS) report, which indicated the Housekeeper (HSK) #167 had witnessed the incident when they had arrived on the floor and an incident occurred between resident #066 and #065. Resident #065 was assessed by the registered staff and was transferred to hospital for further assessment. Resident #065 sustained

injuries.

An interview was conducted with HK #167 who confirmed to have witnessed the incident. The HK stated during the time of the incident it was shift change and the identified floor was in an identified area.

A review of resident #066's clinical records was carried out for an identified period of time, identified the resident to be ambulatory with identified responsive behaviours.

Interviews were conducted with Personal Support Worker (PSW) #164 and PSW #165 on two separate identified dates. The PSW staff indicated they work on an identified floor which consisted of residents who present with responsive behaviours. The PSW's stated that resident #066 will present with identified responsive behaviours when the home area is in an identified state.

During interviews with Registered Practical Nurse (RPN) #121 and #131, on an identified date, the RPN staff indicated they worked on the identified floor and knew resident #066 who presented with identified responsive behaviors.

In an interview with the Acting Director of Care (DOC) #101, indicated that they were aware of the incident which occurred on an identified date, and a CIS report was submitted to the MOHLTC Director. The Acting DOC indicated resident #066 resided on an identified floor of the home and that the resident had responsive behaviours. The Acting DOC reviewed the written plan of care for resident #066 and identified that a known trigger had not been captured for resident #066's responsive behaviours resulting in identified responsive behaviors. The Acting DOC further stated that there were no identified interventions or direction in the written plan of care to staff related to the prevention of escalating behaviours of resident #066 when the floor is in an identified state.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #065 whereby the resident sustained identified injuries.The scope of the incident was a level 1 as it related to one of three residents reviewed. The home had a level 4 compliance history as they had ongoing non-compliance with LTC Act. s19 (1), which included:
-Directors Referral (DR) issued on July 5, 2017, (2017_370649_0014)
-Compliance Order (CO) issued September 28, 2016, (2016_321501-0019)

-Voluntary Plan of Correction (VPC) issues April 16, 2015, (2015_297558_0006) (604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with the requirement under the LTCHA. Specifically, the plan must include:
a) A process to ensure that the written plan of care for all residents at risk of falls include risk and interventions when the resident is in an identified ambulation device.

b) A process to ensure all staff review and follow the written plan of care related to all residents transfer requirements.

Please submit the written plan for achieving compliance for inspection #2018_718604_0002, to Shihana Rumzi, LTC Homes Inspector, MOHLTC, by email to MOHLTCIBCentralE@ontario.ca, by July 23, 2018.

Grounds / Motifs :

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

The home submitted a CIS report on an identified date, to the MOHLTC Director related to a fall which resulted in an incident causing injury to resident #036 for which the resident was transferred to hospital and resulted in a significant change in the resident's health status. The CIS report further stated resident #036, was being provided care by PSW #115 and was transferred from one position to another with an identified ambulation device. The resident fell, sustained injury, and was transferred to the hospital and returned to the home with identified diagnosis.

A review of resident #036's Risk Management record on an identified dated, revealed the resident was not able to turn around at an identified location do to the lack of space. During the transfer, the resident's leg buckled and they fell backwards on to the floor.

A review of resident's Minimum Data Set (MDS) assessment on an identified dated, revealed that the resident had an identified range of motion.

A review of resident #036's written plan of care revealed that resident #036 was identified to be at risk for falls due to their history of falls, and identified limitations. The goal was to have no injury from falls, and one of the interventions was staff to ensure environment was free of clutter.

An interview with resident #036 confirmed that they had fallen because there was not enough room to turn around and sit.

2. The home submitted a CIS report on an identified date, to the MOHLTC Director, related to an incident which caused an injury to the resident for which the resident was transferred to a hospital for further assessment. The CIS further stated that the resident attempted to self-transfer in an identified location of the home fell and sustained injuries. The resident was transferred to hospital and returned that day with injuries.

During an observation carried out on an identified date for resident #038, the inspector found the resident in an identified location of the home in a sliding posture, and not properly positioned. The inspector brought this to the attention of PSW #126.

An interview was carried out with PSW #126 on an identified date. The PSW indicated they had transferred resident #038 that day, and confirmed that they transferred the resident using a pivot technique and indicated that they carried out the transfer alone but needed two staff for transfers.

A review of the post fall assessment records carried out on an identified date for resident #038 indicated that one of the contributing factors of falls for the resident was that poor positioning.

A review of resident #038's MDS assessment carried out for an identified dated revealed that the resident was to be transferred manually with extensive

assistance by two staff.

A review of resident #038's written plan of care for an identified period, indicated under the fall focus that the resident is to be transferred manually with extensive assistance by two staff and the resident utilized an identified ambulation device on and off the unit and staff are to transfer the resident.

An interview was carried out with Registered Nurse (RN) #125 on an identified date. The RN stated PSW staff are not to transfer residents alone. The RN further stated a second staff is required to properly position the resident when in the mobility device. The RN stated PSW #126 should have followed resident #038's written plan of care related to transfers and should have gotten assistance from another PSW for the transfer.

An interview with the home's Administrator was carried out on an identified date. The Administrator stated all staff are expected to follow each resident's written plan of care and the registered staff working on the floor are expected to ensure PSW staff are aware of each resident's written plan of care and provide care as specified in the plan.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #065 whereby the resident sustained identified injuries. The scope of the incident was a level 3 as it related to two of three residents reviewed. The home had a level 4 compliance history as they had ongoing non-compliance with Regulation s. 6. (7) that included:
-Compliance Order (CO) issued July 5, 2017, (2017_370649_0014)
-CO issued November 24, 2016, (2016_353589_0019)
(600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 16th day of July, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Shihana Rumzi

Service Area Office / Bureau régional de services : Central East Service Area Office