Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 18, 2014	2014_168202_0013	T-087-14	Resident Quality Inspection

Licensee/Titulaire de permis

BARRIE LONG TERM CARE CENTRE INC.
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

ROBERTA PLACE
503 ESSA ROAD, BARRIE, ON, L4N-9E4

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

VALERIE JOHNSTON (202), ANN HENDERSON (559), JUDITH HART (513), LAURA BROWN-HUESKEN (503)

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): June 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 2014.

During the course of this inspection, the following inspections were completed: a complaint inspection, T-312-14, three critical incident inspections, T-391-14, T-423-14, T-415-14 and a follow up inspection, T-570-14.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), co director of care (co-DOC), dietitian, food services supervisor (FSS)/nutrition manager (NM), restorative care coordinator (RCC), environmental services supervisor (ESS), cook, physiotherapy assistant (PA), registered nursing staff, personal support workers, private duty nurse (PDN), housekeeping staff, dietary aides, residents, families.

During the course of the inspection, the inspector(s) observed the provision of care to residents, conducted a tour of the home, reviewed clinical records, observed lunch and dinner meal services, reviewed Residents' Council meeting minutes, home's policies related to abuse and neglect, falls prevention, accommodation services, medication administration, immunizations, infection control.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all residents are protected from physical abuse.

Resident #001's plan of care identified the resident as having frail skin and at a high risk for skin breakdown. Clinical record review and staff interviews indicated that on an identified date and time, the resident received a skin tear to an area identified on

his/her body during a staff assisted transfer while in the shower room witnessed by two nursing students. An interview with nursing student #01 indicated that on an identified date, he/she witnessed resident #001 receive a skin tear to his/her body while two staff members were attempting to transfer the resident from the wheelchair to the shower chair in the shower room. Nursing student #01 indicated that PSW #01 appeared to be impatient when assisting the resident with this transfer. The resident was observed to be crying while sitting in his/her wheelchair on the transfer sling and repeatedly lifted his/her arms upwards attempting to grab the sides of the mechanical lift sling. Nursing student #01 indicated that PSW #01 and PSW #02 continually tried to transfer the resident, despite the resident's ongoing resistance, movements, and difficulty in maintaining a safe position in order to proceed.

During the initial stages of the transfer, the resident cried out in pain and stated that PSW #01 hurt his/her arm. Both PSW #01 and PSW #02 stopped the transfer, noticed that the resident was bleeding and a skin tear was present. Nursing student #01 indicated that the incident was so uncomfortable and inappropriate, that both nursing students reported the incident as abuse to their preceptor and the DOC. Interviews with the DOC and the co-DOC indicated that at the time of the reported incident, PSW #01 was sent home immediately and an investigation commenced.

A review of the statements provided from both nursing students and PSW #02, indicated that PSW #01 was rough with the resident during the transfer. The nursing students and PSW #02 confirmed that the resident had verbalized at the time of the incident that, "he/she is always so rough with me, why does he/she always have to be so rough with me".

An interview with PSW #01 indicated that on an identified date and time, he/she and PSW #02 went to transfer the resident from a wheelchair to a shower chair, along with two shadowing nursing students. Prior to transferring the resident, the resident required his/her continence product to be removed. During the removal of the resident's continence product, the PSW indicated that staff struggled to remove the product because the resident was in the wheelchair and on a mechanical lift sling. The resident continued to try and hold onto the sling, however, the resident's arm kept sliding down into the crease of the wheelchair. PSW #01 indicated that he/she had to lift the resident's arms out from the inner crease of the wheelchair arm at least four times, and on the fifth time of lifting the resident's arms out, the resident sustained a skin tear.

PSW #01 indicated that he/she informed the RN that the resident received a skin tear. The RN provided the resident with treatment to the skin tear and then PSW #01 continued to shower the resident.

The Long Term Care Homes Act, 2007, defines physical abuse as the use of physical

force by anyone other than a resident that causes physical injury or pain. Interviews with the DOC and the co-DOC indicated that following the home’s investigation, the home did not find the above incident constituted abuse. The DOC indicated that the resident had very fragile skin and that the witnesses were first year nursing students. [s. 19. (1)]

2. The licensee failed to ensure that all residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff.

Resident #2220's plan of care identified the resident as high risk for falls, uses a wheelchair for mobility, requires two staff assistance with a mechanical lift for all transfers, is continent and prefers to use the toilet, and will become agitated when needing to use the washroom. A review of the resident's clinical records for an identified period of time indicated that the resident had multiple falls involving self-transfers to the washroom. The records indicated that the resident had 41 falls in an identified four month period.
Staff interviews and clinical record review indicated that on an identified date, the resident was agitated, refused to get up for breakfast and was continually trying to self-transfer to get to the bathroom. An interview with PSW #03 indicated that at an identified time, he/she found the resident on the floor outside of the ensuite bathroom. The PSW called an identified RN, who assisted with transferring the resident back to his/her wheelchair. The RN then offered the resident a continence care device, however, the resident refused the device and requested to use the washroom. The PSW indicated that the RN began to yell at the resident and would not let him/her use the washroom and held the washroom door closed to prevent the resident from having access. The RN continued to yell at the resident while he/she forcefully tried to push the resident's wheelchair forward towards the nursing station. The resident held his/her feet pressed down on the floor trying not to be moved to the nursing station. As the RN determined that he/she could no longer push the wheelchair forward, he/she then spun the resident's wheelchair around backwards and pulled the resident to the nursing station. Once the resident was at the nursing station, sitting in his/her wheelchair, the RN was witnessed to walk through a resident activity program in session lead by an identified PA. The PA indicated in an interview that the RN entered the activity room with residents present, yelling profanities and indicating that he/she could not "take this anymore".
An interview with the PA indicated that upon completion of the activity program, he/she left the home area to escort residents to the church area on ground floor. The PA indicated that upon his/her return to the home area at an identified time, he/she

witnessed PSW #03 and the RN dragging the resident across the floor and swung the resident back into his/her wheelchair. The wheelchair rolled backwards a few feet, as the brakes were not locked on the wheelchair. The resident appeared to be angry and was lashing his/her arms around and resisting movement with his/her legs. Two residents nearby witnessed the incident and insisted that the RN stop. The RN proceeded to the nursing station and repeated that he/she was "okay". The PA indicated that he/she reported the incident immediately to the programs manager and the administrator.

An interview with PSW #04, indicated that upon his/her arrival to the home area at an identified time, the RN reported that the above mentioned resident had been agitated all day, he/she wanted things, kept using the call bell and kept asking to go the washroom. PSW #04 indicated that the RN did not want the resident to use the washroom and that the continence device was to be offered to the resident if he/she requested again.

PSW #05 indicated in an interview that he/she worked on the identified home area between an identified time period. PSW #05 indicated that upon his/her arrival on the unit, the RN was very flustered. PSW #05 witnessed the RN pushing the resident forward in his/her wheelchair, the resident was requesting to go to his/her room and the RN stated, "you are not going to your room, and I have had enough". The resident then put his/her feet on the ground to stop the wheelchair from moving; the RN then spun the wheelchair around backwards and pulled the wheelchair. PSW #05 indicated that he/she was unsure why the resident could not use the washroom. At an identified time, the resident requested to use the washroom again and was very agitated. PSW #05 indicated that he/she had to get the resident to the toilet; however, all other staff was on break, except for the RN. PSW #05 indicated that he/she asked the RN for direction and the RN directed him/her to offer the resident a continence device. If the resident is still insisting on using the washroom, the resident was to be allowed to self-transfer, because he/she does it all the time anyway. The RN indicated that as long as staff did not assist him/her with the self-transfer, staff would not get disciplined for assisting the resident without the second staff member and mechanical lift. PSW #05 indicated that he/she allowed the resident to self-transfer to the washroom, remained in the washroom with the resident, and only assisted to pull the resident's pants up after he/she had a large bowel movement. PSW #05 indicated that the resident was no longer agitated.

Staff interviews indicated that the resident is often agitated when he/she needs to use the washroom and will refuse a continence device. Staff indicated that because the resident requires two staff assistance, using a mechanical lift it is challenging to assist the resident. Staff indicated that there are not always two staff available at the same

time to use a mechanical lift, and the resident becomes agitated when he/she has to wait. Staff indicated that because the resident is so persistent upon using the toilet and not the continence device, staff will allow the resident to self-transfer, only to prove to the resident that he/she cannot do it himself safely.
An interview with the DOC indicated that the home initiated an investigation upon receipt of the abuse allegation and the police were notified the following day. PSW #03 was disciplined for improper transferring of a resident by failing to use a mechanical lift. The RN resigned from the home following the incident and the College of Nurses of Ontario has been notified. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During the lunch meal service on June 16, 2014, residents #2154 and #0016 were observed to be served soup thickened to a pudding consistency. Review of clinical records for the residents revealed that the diet order for resident #2154 included puree textured food and regular fluids. The diet order for resident #0016 included puree textured food and nectar thick fluids. The NM confirmed the residents' diet orders on the master diet list and indicated both residents should have received the puree soup, which is thickened to a nectar thick consistency. The NM removed the incorrect soups and provided each resident with the puree nectar thickened soup. The home's policy titled, Multidisciplinary Dining Room, revised October 7, 2013, indicated that residents are to be offered items as identified on their prescribed menu plan. [s. 6. (7)]

2. The written plan of care for resident #2220 directs staff to use a full mechanical lift

with the assistance by two staff for all transfers and toileting. The resident is continent, prefers to use the toilet for all toileting, however, staff may offer a continence care device. Staff interviews indicated that the resident prefers to use the toilet for all his/her continence care needs. Staff indicated that when the continence care device is offered, he/she will refuse to use it and has expressed dislike for its use. Staff indicated that the resident requests to use the washroom frequently, becomes agitated when he/she needs to use the washroom, and if not provided assistance the resident will self-transfer resulting in multiple documented falls. A review of resident #2220's clinical records for an identified period of time, indicated that the resident has had multiple falls involving self-transfers to the washroom. The records indicated that he/she had 41 falls in an identified four month period. Staff indicated, however, that it is difficult to provide a two person mechanical lift transfer to the toilet for the resident upon his/her request because there is generally not enough staff available.
A review of the progress notes for an identified date, indicated that the resident was agitated, attempting to get up and down and out of bed throughout the entire day shift, attempted to self-toilet multiple times, sliding out of his/her wheelchair, and requesting to use the toilet. The RN informed the resident that he/she is unable to use the toilet and offered the resident a continence care device. The resident became very angry, requesting to use the washroom and attempted to hit the RN. An interview with PSW #03 indicated that the resident was not provided assistance to the toilet all day shift, and the resident was only offered the use of a continence care device as directed by the RN. PSW #05 indicated in an interview, that the resident was agitated throughout the day shift and into the evening shift. At an identified date, PSW #05 assisted the resident to the toilet by allowing the resident to self-transfer. The PSW indicated that because there were no other staff available on the home area at the time, with the exception of the RN, he/she decided to stay in the room with the resident, allowing the resident to transfer him/herself to the toilet. PSW #05 confirmed that he/she did not use a full mechanical lift as directed in the written plan of care and only assisted the resident to remove his/her pants. The PSW indicated that because the resident self-transfers him/herself all the time, and that he/she did not assist, touch, or support the resident during this transfer, it would not be considered an improper transfer and he/she would not be disciplined. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The written plan of care for resident #2220 directs staff to use a full mechanical lift with the assistance of two staff for all transfers as the resident is unable to fully weight bear consistently. The home's Fall's Prevention and Management policy, dated September 16, 2013, directs staff use a full mechanical lift when the resident has fallen and is unable to independently get to standing position. On an identified date and time, an identified PA witnessed an identified RN and PSW #03, drag resident #2220 across the floor, with one person on either side of the resident's arms, and swung him/her up onto the wheelchair. The PA confirmed in an interview that the resident was lifted from the floor without the use of a full mechanical lift. On the same day, at a later time, PSW #05 allowed the resident to transfer him/herself to the washroom indicated that he/she only assisted with the resident's pants, and confirmed that no other staff were present and a full mechanical lift was not used. Staff indicated in interviews that the resident is often permitted to transfer him/herself because there are not always two staff available and the mechanical lift is challenging and time consuming for this resident. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: 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 failed to 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.

Staff interviews indicated that on an identified date and time, resident #2220 was found on the floor outside of the ensuite bathroom and assisted back to his/her wheelchair. The resident was then portered to an area by the nursing station, where he/she slid to the floor from the wheelchair. The home's Fall's Prevention and Management policy, dated September 16, 2013, directs registered staff to complete a falls incident progress note, which reflects circumstances of the fall and an assessment of the resident. The DOC indicated in an interview that the falls incident progress note is considered the clinically appropriate assessment instrument for falls. A review of the progress notes revealed that there was no documentation or assessment for the first fall and there was only documentation indicating that he/she slid to the floor from the wheelchair at an unspecified time. An interview with the DOC confirmed that the resident had fallen twice on an identified date, and the resident had not been assessed using a clinically appropriate assessment instrument that is specifically designed for falls. [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 to 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the residents' 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 is fully respected and promoted.

An interview with an identified PDN alleged that an identified RPN had forced medications upon resident #002 and had been observed to also force medications and foods upon other residents while in the dining room. On June 26, 2014, at 5:05 p.m., resident #005 was sleeping in his/her wheelchair while in the dining room awaiting the dinner meal. The inspector observed the identified RPN, approach the resident from behind his/her wheelchair. The RPN did not acknowledge the resident by name or indicate who he/she was, nor what actions he/she was going to take, and without warning attempted to give the resident a spoonful of crushed medications. The RPN held the spoon against the resident’s mouth, relentlessly. The resident in response held his/her mouth firmly shut, the RPN continued to press the spoon against his/her mouth until the resident gave into the nurse and took the medications. The RPN then forced water into the resident's mouth captured the rest of the medications onto a spoon and held the spoon firmly against the resident's mouth waiting for the resident to open her mouth again. The resident appeared to be struggling with the mouthful of water and medications, however, despite the resident's refusal of more, the RPN then forced the remaining medications in the resident's mouth and wiped the resident's mouth with the spoon. The RPN walked away from the resident toward the inspector and stated, "there now it is in and gone". The RPN maintained her position from reaching out from behind the resident throughout the entire medication administration. An interview with the RPN indicated that have to get "medications into residents in any way that you can and when you can." [s. 3. (1) 1.]

2. The licensee 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 is fully respected and promoted.

Resident #2234’s plan of care identified the resident as having dementia and required assistance during meal service. A PSW indicated in an interview that the resident often removed the clothing protector and her clothing became food stained.
On June 16, 2014, resident #2234 was observed at 11:34 a.m. before lunch meal service with food on his/her shirt and pants. The resident was observed in the same stained clothes mid-afternoon.
Two subsequent observations were made on June 18, 2014, when the resident was observed at 2:35 p.m. with food debris on his/her shirt front. On June 19, 2014, the resident was observed at 1:15 p.m. with food debris on his/her shirt front and pants. Two PSWs took the resident to his/her room for toileting assistance and was brought

back out to the home area with the same food stained shirt on. PSW confirmed that the resident's clothing was food stained. [s. 3. (1) 4.]

3. The licensee failed to ensure that the residents' right to be afforded privacy, in treatment and in caring for his/her personal needs, is respected and promoted.

On June 25, 2014, at 10:12 a.m., and on June 26, 2014, at 10:31 a.m., resident #2213 was observed by the inspector, from the resident's open bedroom doorway while in bed, wearing a t-shirt and continence product without a bed sheet cover over him. Resident care was being provided to his/her roommate by a staff member without the privacy curtain drawn. An identified registered staff confirmed the above occurred and that the residents' right to be afforded privacy in treatment had not been fully respected and promoted. [s. 3. (1) 8.]

4. The licensee failed to ensure that the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 are kept confidential in accordance with the Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act is fully respected and promoted.

June 27, 2014, at 11:55 a.m., on home area three, the inspector observed the medication cart to be positioned by the resident's dining room, while the medication pass had commenced. An identified registered staff member left the area leaving the medication cart locked, however, the eMAR tablet screen remained unlocked exposing resident health information. [s. 3. (1) 11. iv.]

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 failed to ensure that the home's Medication Management-Electronic Medication Administration Record (eMAR), revised October 07, 2013 is complied with.

The home's above mentioned policy directs staff to document the administration of the medication on the (eMAR) and failure to sign for a medication indicated that the medication was not given and therefore, considered a medication error of omission.
Resident #2214's plan of care directs registered staff to provide a prescribed analgesic every four hours as needed, for chronic severe pain. A review of resident #2214's individual narcotic and controlled drug count sheets for an identified two month time period indicated that he/she was administered an analgesic 24 identified dates and times.
A review of resident #2214's (eMar) medication administration records for the identified date and time noted above indicated that the 24 administrations of the analgesic had not been documented as administered on the (eMAR). An interview with registered staff and the DOC confirmed that the home's Medication Management-Electronic Medication Administration Record (eMAR) policy, revised October 07, 2013, had not been complied with. [s. 8. (1) (b)]

2. The licensee failed to ensure that the home's Falls Prevention and Management program policy, effective September 16, 2013, is complied with.

The home's Falls Prevention and Management program policy, directs registered staff, after a resident has a fall to complete a fall follow up progress note for at least three shifts following the incident. A review of resident #2241's clinical records, indicated that he/she had a fall on an identified date, and following the incident there were no fall follow up progress notes completed. The restorative care coordinator confirmed that the fall follow up progress notes had not been completed and that the home's policy had not been complied with. [s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

The following observations were made during the time of the inspection:
On June 16, 2014, the tub room #291 on home area three was found to be heavily stained. The tub room #267 on home area two was stained with feces at 9:45 a.m. Inspector returned to observe the tub room #267 at 3:35 p.m. and the tub room had not been cleaned. An interview with an identified registered staff confirmed that tub room #267 had not been cleaned and that feces were present and dried on the tub surface.
On June 18, 2014, home area five shower room #393 had a strong odour of urine. The shower chair was was found with debris and the commode chair had feces on the underside. The DOC confirmed the observations. The inspector observed in tub room #267 a soiled tub chair and a container of blankets being stored in the tub room. The inspector's observations were confirmed by a PSW who indicated that baths had not been completed this morning, therefore, the chair had been left unclean from the previous bath session on June 17, 2014. [s. 15. (2) (a)]

2. On June 23, 2014, at 12:38 p.m., the tub room #391 was observed to contain hair and other debris.
On June 23, 2014, at 3:50 p.m., in lounge areas #364 and #387, the sofa and chair cushions were observed to be soiled.
On June 24, 2014, at 2:10 p.m., a wheeled blue-seated toilet chair in shower room

#371 had heavy residue along the back of the seat.
On June 24, 2014, at 14:18 p.m., the sink in tub room #367 was observed to have heavy dust and soiled taps.
Interviews with the ESS and registered staff confirmed the above observations and stated that these areas were not clean. [s. 15. (2) (a)]

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

On June 16, 2014, during the initial tour of the home, the following were observed:
-home area five dining room had three dining tables with facecloths wedged under the table legs to prevent unsteadiness.
-home area three dining room had two dining tables with paper wedged under the table legs to prevent unsteadiness.
-home area one dining room had one dining table with paper wedged under the table legs to prevent unsteadiness.
PSW staff indicated in interviews that the dining room tables had been unsteady for quite a while and that residents made complaints. An interview with the FSM and ESS confirmed that the dining room tables had facecloths and paper wedged under the legs because they were unsteady. The ESM replaced the feet on the affected dining room tables before the end of the inspection. [s. 15. (2) (c)]

4. On June 20, 2014, at 2:14 p.m., in home area five, dining room floor tiles were observed to be cracked.
On June 23, 2014, the ESS confirmed that the dining room floor tiles were not in a good state of repair. [s. 15. (2) (c)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's abuse policy, titled Resident Rights, Care and Services-Abuse-Zero Tolerance-Staff Acknowledgment, effective September 16, 2013, directs staff to approach the resident from the front and be sure to have the resident's attention before touching or speaking. On June 26, 2014, at 5:05 p.m., resident #005 was sleeping in his/her wheelchair while in the dining room awaiting the dinner meal. The inspector observed an identified RPN, approach the resident from behind his/her wheelchair. The RPN did not acknowledge the resident by name or indicate who he/she was, nor what actions he/she was going to take, and without warning attempted to give the resident a spoonful of crushed medications. The RPN held the spoon against the resident's mouth, relentlessly. The resident in response held his/her mouth firmly shut, the RPN continued to press the spoon against his/her mouth until the resident gave into the nurse and took the medications. The RPN then forced water into the resident's mouth captured the rest of the medications onto a spoon and held the spoon firmly against the resident's mouth waiting for the resident to open his/her mouth again. The resident appeared to be struggling with the mouthful of water and medications, however, despite the resident's refusal of more, the RPN then forced the remaining medications in the resident's mouth and wiped the resident's mouth with the spoon. The RPN walked away from the resident toward the inspector and stated, "there now it is in and gone". The RPN maintained his/her position from reaching out from behind the resident throughout the entire medication administration. An interview with the RPN indicated that have to get "medications into residents in any way that you can and when you can." [s. 20. (1)]

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 failed to ensure that a 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 to the resident immediately reports the suspicion and the information upon which it was based to the Director.

An interview with an identified PDN alleged that an identified RPN had forced medications upon resident #002 and had been observed to also force medications and foods upon other residents while in the dining room. The PDN indicated that she reported the above information to an identified RPN on an identified date in 2014, however, the PDN was advised to take the information to the management or call the Ministry. The RPN confirmed receiving the above allegations from the PDN, however, indicated that she did not report the information further. The RPN indicated that the because the information was received third hand, she believed it would have been better for the PDN to report this to the management herself. Interviews with the DOC and the administrator indicated no knowledge of the reported allegations received by the RPN and therefore, they did not report the incident to the Director. [s. 24. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home receives finger nail care, including the cutting of fingernails.

On June 20, 2014, at 3:15 p.m., resident #2154's left hand's thumb nail was observed to be long with a sharp edge and corner. The index finger nail was observed to be long and untrimmed. The fingers of the right hand were observed to be curling inward, all nails on all fingers of the right hand were long and there was an unclean scent of perspiration from the right hand.
Resident #2154's written plan of care identified the resident with a medical condition and directs registered staff to trim his/her nails on first bath day of the week.
On June 25, 2014, at 5 p.m., an identified registered staff confirmed that the resident's fingernails on both hands were too long and required trimming. [s. 35. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his/her preferences, in his/her own clean clothing.

Resident #2234's plan of care identified the resident as having a cognitive impairment and required assistance during meal service. A PSW indicated in an interview that the resident often removed the clothing protector and his/her clothing became food stained.
On June 16, 2014, resident #2234 was observed before lunch meal service with food on his/her shirt and pants. The resident was observed in the same stained clothes mid-afternoon.
Two subsequent observations were made on June 18, 2014, when the resident was observed at 2:35 p.m. with food debris on his/her shirt front. On June 19, 2014, the resident was observed at 1:15 p.m. with food debris on his/her shirt front and pants. Two PSWs took the resident to his/her room for toileting assistance and was brought back out to the home area with the same food stained shirt on. PSW confirmed that the resident's clothing was food stained. PSW stated his/her shirt will be changed after the snack later in the afternoon. [s. 40.]

WN #12: 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 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 is specifically designed for skin and wound assessment.

A review of the progress notes for resident #2245 on an identified date, indicated that the resident sustained an injury causing a skin tear.
In an interview the DOC confirmed that a skin assessment had not been completed for the resident by registered staff using a clinically appropriate assessment instrument specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council.

The President of Residents' Council indicated in an interview that meal times were discussed at Residents' Council, but he could not recall that snack times were discussed.
The FSM and the DOC acknowledged that snack times were not documented as having been reviewed by Residents' Council. [s. 73. (1) 2.]

2. The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

During the lunch meal service on June 16, 2014, residents #2154 and #2234 were observed to be consuming their entrees, and at this time they were served dessert. Review of the clinical records for the residents revealed that the residents had not been assessed to require service of multiple courses at one time. The home' policy titled, Multidisciplinary Dining Room, revised October 7, 2013, indicated that residents will be served their meals one course at a time unless otherwise requested by the resident. The NM confirmed that the residents should not have been served dessert until their entrées were completed and that the residents had not been provided course by course meal service. [s. 73. (1) 8.]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that copies of the inspection reports from the past two years for the long-term care home are posted in the home.

On June 27,2014, the inspector observed the following inspection reports were not posted in the home:
2014_299559_0001 from January 16, 2014.
2013_109153_0005 from April 12, 2013.
2013_157210_0002 from March 13, 2013.
The absence of the reports was confirmed in an interview with the administrator. [s. 79. (3) (k)]

WN #15: 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,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair.

On June 18, 2014, the right arm rest on a Versa frame around the toilet of an identified room was found to be broken. The ESS indicated in an interview that staff are directed to enter any equipment repairs to be addressed in the home's maintenance book as part of the home's maintenance procedures. The ESS confirmed, however, that staff did not enter the broken Versa frame arm rest in the maintenance book and therefore was not replaced or repaired. The ESS indicated that the Versa frame required replacement and confirmed that the home's maintenance procedures had not been implemented. [s. 90. (2) (b)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs are stored are kept locked at all times when not in use.

June 27, 2014, at 11:45 a.m., on an identified home area, the inspector observed the medication room to be unlocked with no staff presence. An identified RPN confirmed that the medication storage room was unlocked at the time and not in use. [s. 130. 1.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Resident #2214's plan of care directs registered staff to administer a prescribed analgesic every four hours as needed. A review of the resident's clinical records and staff interviews confirmed that on an identified date and time, the resident received an incorrect dosage of the analgesic prescribed. The physician was notified and no ill effects occurred to the resident. [s. 131. (1)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

The home's policy titled, Required Programs-Pain, effective September 16, 2013, directs staff to monitor and document the effectiveness of a PRN pain management intervention when administered to a resident. Resident #2214's plan of care directs registered staff to provide an identified analgesic every four hours as needed for chronic severe pain. Staff are directed to document effectiveness of PRN analgesics after administration. A review of resident #2214's individual narcotic and controlled drug count sheets for an identified two month period of time indicated that he/she was administered an analgesic on 24 identified dates and times.
A review of resident #2214's clinical records for the two month time period did not reveal evidence of monitoring and documentation for the resident's response and the effectiveness of the analgesic received on the dates and times identified. Interviews with registered staff confirmed that the monitoring and documenting the resident's response and effectiveness of PRN analgesics had not been completed for the above date and times and is not consistently done. [s. 134. (a)]

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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee

Resident #2241 was admitted to the home on an identified date, and received step one testing for tuberculosis at this time, however, the second step for tuberculosis testing had not been completed. On an identified date, the physician wrote an order for the resident to have a chest x-ray for tuberculosis testing, however, the x-ray remains outstanding at the time of this inspection. During an interview, a registered staff member confirmed the order had been received but the chest x-ray had not occurred. The co-DOC confirmed in an interview that the resident's second step was not completed initially, and that this resident had not received a chest x-ray for tuberculosis testing. [s. 229. (10) 1.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 33. (1)	CO #001	2014_312503_0010	559

Issued on this 6th day of October, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE JOHNSTON (202), ANN HENDERSON (559), JUDITH HART (513), LAURA BROWN-HUESKEN (503)
Inspection No. / No de l'inspection :	2014_168202_0013
Log No. / Registre no:	T-087-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 18, 2014
Licensee / Titulaire de permis :	BARRIE LONG TERM CARE CENTRE INC. 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	ROBERTA PLACE 503 ESSA ROAD, BARRIE, ON, L4N-9E4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CAROLYN MCLEOD

To BARRIE LONG TERM CARE CENTRE 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 shall prepare, submit and implement a plan to ensure that all residents are protected from physical abuse by anyone and that residents are not neglected by the licensee or staff. The plan should include, but not limited to ensuring appropriate assistance is provided by staff to residents as directed in the residents plan of care, specifically related to transferring and toileting. Please submit the plan to valerie.johnston@ontario.ca by September 19, 2014.

Grounds / Motifs :

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

Resident #2220's plan of care identified the resident as high risk for falls, uses a wheelchair for mobility, requires two staff assistance with a mechanical lift for all transfers, is continent and prefers to use the toilet, and will become agitated when needing to use the washroom. A review of the resident's clinical records for an identified period of time indicated that the resident had multiple falls involving self-transfers to the washroom. The records indicated that the resident had 41 falls in an identified four month period.
Staff interviews and clinical record review indicated that on an identified date, the resident was agitated, refused to get up for breakfast and was continually trying to self-transfer to get to the bathroom. An interview with PSW #03 indicated that at an identified time, he/she found the resident on the floor outside of the ensuite bathroom. The PSW called an identified RN, who assisted with transferring the resident back to his/her wheelchair. The RN then offered the resident a continence care device, however, the resident refused the device and requested to use the washroom. The PSW indicated that the RN began to yell at the resident and would not let him/her use the washroom and held the

washroom door closed to prevent the resident from having access. The RN continued to yell at the resident while he/she forcefully tried to push the resident's wheelchair forward towards the nursing station. The resident held his/her feet pressed down on the floor trying not to be moved to the nursing station. As the RN determined that he/she could no longer push the wheelchair forward, he/she then spun the resident's wheelchair around backwards and pulled the resident to the nursing station. Once the resident was at the nursing station, sitting in his/her wheelchair, the RN was witnessed to walk through a resident activity program in session lead by an identified PA. The PA indicated in an interview that the RN entered the activity room with residents present, yelling profanities and indicating that he/she could not "take this anymore".
An interview with the PA indicated that upon completion of the activity program, he/she left the home area to escort residents to the church area on ground floor. The PA indicated that upon his/her return to the home area at an identified time, he/she witnessed PSW #03 and the RN dragging the resident across the floor and swung the resident back into his/her wheelchair. The wheelchair rolled backwards a few feet, as the brakes were not locked on the wheelchair. The resident appeared to be angry and was lashing his/her arms around and resisting movement with his/her legs. Two residents nearby witnessed the incident and insisted that the RN stop. The RN proceeded to the nursing station and repeated that he/she was "okay". The PA indicated that he/she reported the incident immediately to the programs manager and the administrator.
An interview with PSW #04, indicated that upon his/her arrival to the home area at an identified time, the RN reported that the above mentioned resident had been agitated all day, he/she wanted things, kept using the call bell and kept asking to go the washroom. PSW #04 indicated that the RN did not want the resident to use the washroom and that the continence device was to be offered to the resident if he/she requested again.
PSW #05 indicated in an interview that he/she worked on the identified home area between an identified time period. PSW #05 indicated that upon his/her arrival on the unit, the RN was very flustered. PSW #05 witnessed the RN pushing the resident forward in his/her wheelchair, the resident was requesting to go to his/her room and the RN stated, "you are not going to your room, and I have had enough". The resident then put his/her feet on the ground to stop the wheelchair from moving; the RN then spun the wheelchair around backwards and pulled the wheelchair. PSW #05 indicated that he/she was unsure why the resident could not use the washroom. At an identified time, the resident requested to use the washroom again and was very agitated. PSW #05 indicated that he/she had to get the resident to the toilet; however, all other staff

was on break, except for the RN. PSW #05 indicated that he/she asked the RN for direction and the RN directed him/her to offer the resident a continence device. If the resident is still insisting on using the washroom, the resident was to be allowed to self-transfer, because he/she does it all the time anyway. The RN indicated that as long as staff did not assist him/her with the self-transfer, staff would not get disciplined for assisting the resident without the second staff member and mechanical lift. PSW #05 indicated that he/she allowed the resident to self-transfer to the washroom, remained in the washroom with the resident, and only assisted to pull the resident's pants up after he/she had a large bowel movement. PSW #05 indicated that the resident was no longer agitated.
Staff interviews indicated that the resident is often agitated when he/she needs to use the washroom and will refuse a continence device. Staff indicated that because the resident requires two staff assistance, using a mechanical lift it is challenging to assist the resident. Staff indicated that there are not always two staff available at the same time to use a mechanical lift, and the resident becomes agitated when he/she has to wait. Staff indicated that because the resident is so persistent upon using the toilet and not the continence device, staff will allow the resident to self-transfer, only to prove to the resident that he/she cannot do it himself safely.
An interview with the DOC indicated that the home initiated an investigation upon receipt of the abuse allegation and the police were notified the following day. PSW #03 was disciplined for improper transferring of a resident by failing to use a mechanical lift. The RN resigned from the home following the incident and the College of Nurses of Ontario has been notified. (202)

2. The licensee failed to ensure that all residents are protected from physical abuse.

Resident #001's plan of care identified the resident as having frail skin and at a high risk for skin breakdown. Clinical record review and staff interviews indicated that on an identified date and time, the resident received a skin tear to an area identified on his/her body during a staff assisted transfer while in the shower room witnessed by two nursing students. An interview with nursing student #01 indicated that on an identified date, he/she witnessed resident #001 receive a skin tear to his/her body while two staff members were attempting to transfer the resident from the wheelchair to the shower chair in the shower room. Nursing student #01 indicated that PSW #01 appeared to be impatient when assisting the resident with this transfer. The resident was observed to be crying while sitting in his/her wheelchair on the transfer sling and repeatedly lifted his/her

arms upwards attempting to grab the sides of the mechanical lift sling. Nursing student #01 indicated that PSW #01 and PSW #02 continually tried to transfer the resident, despite the resident's ongoing resistance, movements, and difficulty in maintaining a safe position in order to proceed.
During the initial stages of the transfer, the resident cried out in pain and stated that PSW #01 hurt his/her arm. Both PSW #01 and PSW #02 stopped the transfer, noticed that the resident was bleeding and a skin tear was present. Nursing student #01 indicated that the incident was so uncomfortable and inappropriate, that both nursing students reported the incident as abuse to their preceptor and the DOC. Interviews with the DOC and the co-DOC indicated that at the time of the reported incident, PSW #01 was sent home immediately and an investigation commenced.
A review of the statements provided from both nursing students and PSW #02, indicated that PSW #01 was rough with the resident during the transfer. The nursing students and PSW #02 confirmed that the resident had verbalized at the time of the incident that, "he/she is always so rough with me, why does he/she always have to be so rough with me".
An interview with PSW #01 indicated that on an identified date and time, he/she and PSW #02 went to transfer the resident from a wheelchair to a shower chair, along with two shadowing nursing students. Prior to transferring the resident, the resident required his/her continence product to be removed. During the removal of the resident's continence product, the PSW indicated that staff struggled to remove the product because the resident was in the wheelchair and on a mechanical lift sling. The resident continued to try and hold onto the sling, however, the resident's arm kept sliding down into the crease of the wheelchair. PSW #01 indicated that he/she had to lift the resident's arms out from the inner crease of the wheelchair arm at least four times, and on the fifth time of lifting the resident's arms out, the resident sustained a skin tear.
PSW #01 indicated that he/she informed the RN that the resident received a skin tear. The RN provided the resident with treatment to the skin tear and then PSW #01 continued to shower the resident.
The Long Term Care Homes Act, 2007, defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain. Interviews with the DOC and the co-DOC indicated that following the home's investigation, the home did not find the above incident constituted abuse. The DOC indicated that the resident had very fragile skin and that the witnesses were first year nursing students. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 18th day of August, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Johnston

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