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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 22, 2016	2016_290551_0006	005515-16	Resident Quality Inspection

Licensee/Titulaire de permis

ST. PATRICK'S HOME OF OTTAWA INC.
2865 Riverside Dr. OTTAWA ON K1V 8N5

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

ST PATRICK'S HOME
2865 RIVERSIDE DRIVE OTTAWA ON K1V 8N5

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

MEGAN MACPHAIL (551), ANANDRAJ NATARAJAN (573), GILLIAN CHAMBERLIN (593), LINDA HARKINS (126), RENA BOWEN (549), RUZICA SUBOTIC-HOWELL (548)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 24 and 29, 2016.

The following logs were inspected:
- related to allegations of abuse: 017421-15, 023219-15, 026165-15, 026316-15, 026360-15, 027649-15, 028512-15, 032390, 032836-15, 033700-15, 034117-15, 035918-15, 000374-16, 002413-16, 006129-16
- related to falls: 006485-15, 013287-15, 021904-15, 024751-15, 027188-15, 029814-15, 034589-15, 006301-16, 006329-16
- related to admission processes: 036238-15
- related to compliance orders: 000309-16, 000310-16
- related to a medication incident: 002387-16

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Nursing Staff, Dietary Aides, Food Service Supervisors, a Maintenance Worker, the Vice President (VP) of Maintenance, the Wound Care Champion, a Finance Worker, the Rehabilitation Lead Hand, the Clinical Practice and Performance Coordinator, the Manager of Support Services, the Human Resources (HR) Manager, a Physician, the Admission Clerk, a Payroll/HR Worker, a Physiotherapist, a Physiotherapist Assistant (PTA), the Vice President (VP) of Clinical Care, the Acting Vice President (VP) of Programs and the President and CEO.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Admission and Discharge
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation

During the course of this inspection, Non-Compliances were issued.
- **19 WN(s)**
- **15 VPC(s)**
- **0 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. 6. (1)	CO #002	2015_288549_0034	549
LTCHA, 2007 S.O. 2007, c.8 s. 86. (3)	CO #001	2015_288549_0034	549

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. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to resident #070.

Observations by Inspector #593 from March 22 – 24, 2016, found resident #070 seated in a wheelchair with a front closing seat belt applied.

A review of resident #070's current care plan found multiple interventions documented related to the resident's ambulation including "uses assistive device (walker) for ambulation", "wheelchair with seat belt to be used at all times, as agreed by POA", "ambulation with 4WW for endurance with supervision" and "ensure that resident has his/her walker".

During an interview with Inspector #593 on March 23, 2016, PSW #150 reported that resident #070 only uses a wheelchair during meals and after meals he/she is walked by staff with the walker, and then he/she is seated back in his/her wheelchair by the next meal.

During an interview with Inspector #593 on March 23, 2016, RPN #124 reported that until recently, the resident was ambulating with a walker however the resident now ambulated with a wheelchair as he/she was having multiple falls. RPN #124 further added that the resident sometimes uses his/her walker from his/her bed to the bathroom but only when accompanied by a staff member.

During an interview with Inspector #593 on March 24, 2016, Restorative Services staff

member #106 reported that resident #070 uses a four point belt for posture and positioning when in the wheelchair however he/she only uses the wheelchair when required as he/she still ambulates with his/her walker with one staff assistance.

During an interview with Inspector #593 on March 24, 2016, the Vice-President of Clinical Services confirmed that there was conflicting information in the written care plan and the resident's actual care, and what is actually happening should be identified in the care plan specifically related to resident #070's ambulation. [s. 6. (1) (c)]

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

This finding is related to Log# 034589-15 / CIR #C569-000100-15.

Resident #053 was admitted to the home on a specified date in December 2015. At the time of admission the resident was assessed as being at high risk for falls.

The home submitted CIR #C569-000095-15 indicating that the resident had an unwitnessed fall requiring hospitalization. The resident returned from the hospital seven days later.

The written plan of care was updated upon the resident's return from hospital to include: bed alarm-applied while resident is in bed and chair alarm- applied while resident is seated.

The home submitted another CIR #C569-000100-15 indicating that the resident had an unwitnessed fall which resulted in transfer to hospital.

The CIR #C569-000100-15 indicated that the resident was in bed before the fall and did not have the portable alarm applied to the bed.

The unit RPN indicated in the progress notes on a specified day, post fall, that the portable alarm was on the resident's tilt wheel chair at the time of residents fall from the bed.

During a telephone interview on March 16, 2016, RN #121 confirmed that on a specified day, resident #053 was transferred from the tilt wheelchair to the bed. After resident #053 was transferred to bed the portable alarm from the tilt wheelchair was not transferred to

the bed putting the resident at risk.

In summary the portable alarm was not applied to the bed when the resident was transferred to bed as per the care set out in the plan of care for resident #053 resulting in a transfer to hospital. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident #084 as specified in the plan.

This finding is related to Log # 006329-16 / CIR # C569-000011-16.

Resident #084 was admitted to the home on a specified day in September 2015. Resident #084's health care records identified that the resident is at high risk for falls and has history of multiple falls since admission.

Resident #084's plan of care in effect was reviewed by the inspector. The fall prevention interventions identified in the written plan of care include the use of a bed/chair alarm, hip protectors and hourly safety checks.

On March 29, 2016, during meal time Inspector #573 observed resident #084 sitting in a wheel chair without any chair alarm attached to the resident. At 1236, the inspector observed that the resident was lying in bed with no bed alarm attached and also with no hip protectors in place.

Inspector #573 interviewed PSW #160 about resident #084's bed/wheelchair alarm and hip protectors. PSW #160 indicated that she did not apply the bed alarm and hip protectors for the resident since the resident does not like the sound when the alarm goes off.

On March 29, 2016, Inspector #573 spoke with home's Restorative Lead and RN #162, and both stated that PSW staff members were supposed to apply the bed/chair alarm and hip protectors for resident #084 twenty-four hours a day, seven days a week.

Resident #084's initial physiotherapy assessment identified that the resident was in physiotherapy treatment for multiple interventions including balance and strengthening exercises.

Upon reviewing the resident's physiotherapy daily schedule sheet for a three month

period from January 2016 to March 2016, there is no documentation that resident #084 was provided with balance and strengthening exercises.

On March 29, 2016, Physiotherapist Assistant (PTA) #163 indicated that resident #084 was not provided with all the physiotherapy interventions, and furthermore the PTA indicated that the resident was seen for the walking program only and not for balance and strengthening exercises.

During an interview with Inspector #573, the home's Physiotherapist indicated that the PTA is expected to provide all of the physiotherapy interventions in place unless the resident refused the treatment.

Resident #084's fall prevention and the physiotherapy interventions set out in the plan of care were not provided to the resident as specified in the plan. [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 1. the written plan of care for resident #070 sets out clear directions to staff regarding ambulation. 2. to ensure that the care set out in resident #053's plan of care with regards to a portable alarm is provided. 3. to ensure that resident #084's fall prevention and the physiotherapy interventions set out in the plan of care are provided, to be implemented voluntarily.

WN #2: 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. In accordance with O.Regs 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1.There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
The home does have a Prevention and Management Policy (IX NSG E-11.00). Under Procedure section Post Fall Assessment, it is required that :
The Registered Nurse:
4. Initiate a head injury routine (HIR) if a head injury is suspected or if the resident fall is unwitnessed and he/she is on anticoagulant therapy.
5. Monitor HIR for 48 hours post fall for signs of neurological changes, i. e. facial droop, behavioral changes, weakness on one side etc.
7. RNs complete a CIS if Resident sent to hospital for evaluation
The Head Injury Routine (HIR) Policy (IX NSG E-11.00(a)). Under Procedure it is required that:
"The RN/RPN:
2. Provide first aid to any open wound and if no open wounds are evident and the resident has not lost consciousness but the resident is known to have struck their head, treat the resident in accordance with the head injury protocol.

Head Injury Routine:
Head Injury Routine is done every 15 minutes for an hour, until the resident's physician is contacted, and if no alternate orders are given by the resident's physician, monitor and

document the resident's pulse, respirations, blood pressure, pupil reaction, level of consciousness, limb and/or involuntary body movement, evidence of nausea, vomiting, headache, change in mental status immediately at the time of injury and on the following schedule:
Every 15 minutes x 1 hour
Every 30 minutes x 2 hours
Every 1 hour x 8 hours
Every 4 hours x 12 hours or until directed by the physician to cease monitoring."
Report any changes in the resident's vital signs, level of consciousness, pupillary reaction, vomiting or bleeding from the eyes, nose, ears or mouth to the attending physician immediately.

Resident #045 was admitted to the home on a specified day in July 2015 with specific diagnosis. Resident #045 was alert and oriented and was ambulating with a walker.

On a specified day at a specified time, it is documented in the progress notes that resident #045 was found lying on the floor, and that he/she indicated that he/she had lost his/her balance and fell. Resident #045 indicated that he/she had hit his/her head. A head to toe assessment was completed, vital signs (v/s) were taken, and the resident was able to move his/her limbs. Resident #045 was assisted off the floor with the assistance of two staff. The Registered Nurse(RN) was notified, and the Head Injury Routine was initiated.

On March 11, 2016, Inspector #126 reviewed resident #045 health care record (including electronic copy and paper copy) for the N-85, Head Injury Routine Monitoring Record (HIRMR) and was not able to locate it.

The progress notes indicate that HIR was initiated at a specified time on a specified date, and was ongoing at two specified times on specified dates.

As N-85, Head Injury Routine Monitoring Record (HIRMR) was not available, there is no documentation that the HIR was completed as required as per the policy (every 15 minutes x 1 hour and every 30 minutes x 2 hours and every 1 hour x 8 hours).

A discussion was held with the Clinical Practice and Performance Coordinator who reviewed resident #045's health care record with Inspector #126 and indicated that N-85 (HIRMR) was not found in the health care record.

On a specified day at a specified time, it is documented in the progress notes that resident #045 was confused and acted out of character. The physician was not contacted immediately as per requirement "Report any changes in the resident's level of consciousness".

There is documentation indicating that the resident continued to be monitored, however after a specified day and time, there is no documentation in the progress notes that the HIR was continued.

[s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system is complied with. In accordance with, O.Reg 79/10 r. 52 Pain Management.

This finding is related to Log # 006485-15 / CIR # C569-000037-15 and C569-000041-15.

The home submitted two critical incidents for resident #069 related to falls. CIR#: C569-000037-15 described an unwitnessed fall where the resident was found in his/her room lying on the floor. The resident was transferred to hospital. CIR#: C569-000041-15 indicated that resident's #069 bed alarm activated and the resident was found lying on the floor. The resident was sent to hospital.

Resident #069 requires different levels of assistance for completion of activities of daily living.

The home's policy titled: Pain and Symptom: Assessment and Management, IX NSG E-10.00 revision date July 2015 specifies that a pain assessment is to be conducted by registered staff on re-admission, with the initiation of PRN analgesic and when a resident is receiving a pain medication for greater than 72 hours. In addition, the type of pain is to be determined utilizing the PCC pain assessment. Accompanying the policy is a tool titled: 24 HR Pain and Symptom Monitoring Tool IX NSG E-10.00a.

During an interview, the Acting VP of Nursing indicated that registered nursing staff are to conduct and document a pain assessment when a resident has a change in health status, exhibits behaviours of pain or with the initiation of a pain medication.

The health care record was reviewed. Progress note entries indicated:

On several specified days, the resident was given a specific medication due to reports of pain.

During an interview with Inspector #548, RPN #112 indicated that resident #069 was difficult to assess for pain. Also, she indicated that the specific medication was prescribed for pain management. In addition, RPN #112 indicated that the home has a Pain Monitoring Flow Sheet, N-152, dated April 2011 that is to be utilized for the monitoring of resident pain.

Review of the health record with the RPN #112 concluded there is no pain assessment tool for resident #069. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Fall Management and Pain Management policies are complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On March 08, 2016, Inspector #548 observed resident #018's wheelchair to have dried dark coloured spots on both arm rests.

On March 10, 2016 Inspector #549 observed resident #018's wheelchair to have dried dark red colour debris and white spots on both arm rests.

Inspector #549 observed the same wheelchair on March 11 and 14, 2016 to have the same dried dark red colour debris and white spots on both of the arm rests.

On March 08, 2016, Inspector #551 observed resident #028's wheelchair to have white spots of debris on the back of the head rest and frame.

On March 10, 2016, Inspector #549 observed resident #028's wheelchair to have dried debris on the left side of front of the seat cushion running down to the left side of leg and foot rest.

Inspector #549 observed the same wheelchair on March 11 and 14th to have the same dried debris on the left side of the front of the seat cushion running down the left side of the leg and foot rest.

On March 08, 2016, Inspector #551 observed resident #027's electric wheelchair to have debris throughout the entire wheelchair.

On March 10, 2016, Inspector #549 observed resident #027's electric wheelchair to have debris and a thick layer of dust on the back of the wheelchair frame and shelve. It was also noted that the wheelchair had silver duct tape wrapped around both foot pedals that was torn and had black debris stuck to them. The wheels of the wheelchair also have dried debris on them.

On March 11 and 14, 2016 Inspector #549 observed the same debris, thick layer of dust and silver duct tape on the electric wheelchair of resident #027.

On March 11, 2016, Inspector #549 observed resident #051's wheelchair to have dried dark debris on both arms of the wheelchair, the left side of the frame and white dried debris on the front left side of the cushion.

On March 14, 2016, Inspector #549 observed the same wheelchair to have the same

debris on it.

On March 11 and 14th, 2016 Inspector #549 observed resident #050's wheelchair to have dried debris on the left arm rest and the left front of the seat cushion

During an interview on March 10, 2016 with PSW # 110 and PSW #111 it was indicated to Inspector #549 that the resident's wheelchairs are sent down to the basement when the wheelchairs are dirty with debris. The PSW's indicated that when a resident's wheelchair or walker looks like it needs to be cleaned they will leave a message for the Rehabilitation Lead Hand who will put the resident's name on a list for cleaning. The PSWs also indicated that there is no cleaning schedule for the wheelchairs and walkers.

The PSWs indicated that they are to clean the wheelchairs on day to day to day basis to remove debris if required and time permitting.

On March 11, 2016 during an interview with RPN #120, it was indicated to Inspector #549 that the PSWs are responsible for the day to day spot cleaning of the wheelchairs and walkers.

During an Interview with the Acting Vice President (VP) Nursing Programs on March 11, 2016 it was indicated to Inspector #549 that the PSWs are responsible for the day to day spot cleaning of the resident's wheelchairs and walkers. The Acting VP Nursing Programs also indicated during the interview that the home's expectation is that the resident's wheelchairs and walkers be spot cleaned when required between the steam cleaning.

During an interview on March 11, 2016 with the Manager of Support Services it was indicated to Inspector #549 that the support services department is responsible for the steam cleaning of the resident's walkers and wheelchairs.

The Manager of Support Services indicated that there is scheduled time every night shift for five wheelchairs or walkers to be steam cleaned, however there is no tracking of the residents who have had their wheelchair or walker cleaned.

The Manager of Support Services also indicated that the Rehabilitation Lead Hand is responsible for ensuring that the resident's wheelchairs and walkers that the resident home areas request to be cleaned are put on the cleaning list for support services. The Manager of Support Services also indicated that one of the suppliers comes in to the

home once a year to clean the resident's wheelchairs and walkers.

The Manager of Support Services indicated to Inspector #549 that there is a cleaning product in each utility room for the PSWs to clean the resident's wheelchairs and walkers in between the steam cleaning. PSW #110 and PSW #111 were not aware of the product in the clean utility room for the day to day cleaning of the resident's wheelchairs and walkers.

On March 11, 2016 during an interview with the Rehabilitation Lead Hand it was indicated to Inspector #549 that the staff on each of the resident units will request a wheelchair or walker to be steamed cleaned. The Rehabilitation Lead Hand will then ensure that the particular wheelchair or walker be put on the list for the support services staff to clean. The Rehabilitation Lead Hand confirmed that there is no regular cleaning schedule for resident's wheelchair or walkers.

The Rehabilitation Lead Hand confirmed with Inspector #549 that there is no tracking of when a resident had their wheelchair or walker steam cleaned and there is no documentation or schedule for the cleaning of the resident's wheelchairs or walkers in between the steam cleaning. [s. 15. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident's ambulation equipment is kept clean and sanitary, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's written policy (Resident Abuse: Definitions, I ADM G 10.03 (a) and Resident Abuse: Prevention, Reporting and Elimination, I ADM G 10.03) under section 20 of the Act to promote zero tolerance of abuse and neglect of residents:
b) clearly sets out what constitutes abuse and neglect. For example:
- does not state that financial abuse means any misappropriation or misuse of a resident's property (speaks to money only)
- does not state that physical abuse means the use of physical force by anyone other than a resident that causes physical injury or pain, and the use of physical force by a resident that causes physical injury to another resident
- does not state that sexual abuse means any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or staff member
d) contains an explanation of the duty under section 24 of the Act to make mandatory reports. The licensee's policy directs staff to report abuse by completing an Abuse Form within five business days and to complete the investigation within a month.

On March 18, 2016, Inspector # 126 interviewed the President and Chief Executive Officer regarding the abuse policy. It was discussed that the home's abuse policy does not meet all criteria as per the legislation. [s. 20. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the written policy to promote zero tolerance of abuse and neglect of residents. 1. clearly sets out what constitutes abuse and neglect. 2. contains an explanation of the duty under section 24 of the Act to make mandatory reports, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated.

This finding is related to Log # 026360-15 / CIR #C569-000076-15 and Log #026316-15 / CIR # C569-000074-15.

The home submitted CIR #C569-000074-15 and CIR #C569-000076-15 on specified days. Both CIRs describe the alleged abuse of resident #065 and resident #060 by PSW #138 and witnessed by RPN #137. The CIRs included statements from both of the residents.

On a specified day, RPN #137 sent an email to the VP of Clinical Care, the VP of Nursing Programs, the CEO and President and the HR Manager. The email included a description of the incident and the residents' reactions.

When interviewed, RPN #137 indicated that she contacted unit RN #139 on a specified day to inform the RN of the witnessed incidents of the abuse of resident #060 and resident #065. RPN #137 also indicated that she spoke with RN #125 who was the RN in charge to inform her of the witnessed incidents of the abuse of resident #060 and resident #065. RPN #137 indicated that RN #125 instructed her to send an email to management.

RN #125 indicated during an interview with Inspector #549, that she could not remember RPN #137 informing her of the witnessed abuse of resident #060 and resident #065 by PSW #138.

RN #139 indicated during an interview with Inspector #549, that she did not think the incident was abuse. RN #139 indicated to Inspector #549 that she is aware now that the incident is considered abuse.

On a specified day, the CEO and President sent an email to RPN #137, the VP of Clinical Care, the VP of Nursing Programs and the HR Manager indicating the abuse of resident #060 and resident #065, to submit a Critical Incident Report and that "the staff member should be off while the investigation is being conducted".

During an interview with the VP of Clinical Care, it was indicated to Inspector #549 that the investigation of the suspected abuse of resident #060 and resident #065 on a specified day was not investigated immediately. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by another resident which resulted in harm was not immediately reported to the Director.

This finding is related to Log #032836-16 / CIR # C569-000089-15.

On a specified day, resident #054 was walking back to his/her room and had an encounter with resident #055 who acted out physically and verbally towards resident #054.

It is documented in the Critical Incident Report that the Vice President of Nursing met with resident #054's Power Of Attorney (POA) on the same day that the incident occurred.

The VP of Programs was aware of the incident on a specific day as evidenced by her meeting with resident #054's daughter and documenting this meeting in the CIR.

The incident of abuse was not reported immediately to the Director as it was reported three days after the incident. [s. 24. (1)]

2. The licensee has failed to ensure that a person who had reasonable grounds to

suspect that abuse of a resident by anyone occurred was immediately reported to the Director.

This finding is related to Log # 017421-15 / CIR # C569-000057-15.

On a specified day at at specified time, Dietary Aide #136 witnessed an incident of suspected sexual abuse between resident #061 and a visitor.

In an interview with the Dietary Aide, she reported that after instructing a recreation staff member to check on resident #061, she immediately reported the incident to the RPN #167.

In an interview with RPN #167, she stated that upon becoming aware of the incident, she went to the Clinical Practice and Performance Coordinator (CPPC) in order to inform him of the incident and to seek clarification as to whether she should chart on it. The RPN stated that she was directed to have Dietary Aide #136 report to her manager.

In an interview with the CPPC, he stated that the incident was hear say so he directed the RPN to have the Dietary Aide go to her direct manager. He stated that suspected abuse is to be reported to the staff member's direct manager.

Food Service Supervisor #135 was interviewed and confirmed that Dietary Aide #136 did come to her to report the incident. The Food Service Supervisor could not recall when she was informed of the incident, and stated that it was during the day shift. Food Service Supervisor #135 reported that she thinks she would have sent an email notification to her manager (Manager of Support Services) but was not able to verify this.

A review of the home's investigation notes showed that on the day of the incident, Food Service Supervisor #135 sent an email to Nutritional Supervisors from Nutritional Supervisors indicating "I don't know who this should be sent to" and went on to outline the incident as reported to her.

According to information contained in the CIR, the VP of Nursing Programs was informed of the allegation of sexual abuse involving Resident #061 the following day 2015 by Food Service Supervisor #122.

The Director was informed of the suspected abuse two days after the incident occurred. [s. 24. (1)]

3. The licensee failed to ensure that 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: (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.

This finding is related to Log # 033700-15 / CIR # C569-000090-15.

A critical incident report (CIR) #C569-000090-15 was submitted to the MOHLTC describing an alleged abuse/neglect from a staff member to resident #063. The incident was described by the resident to have occurred between specific hours on a specific date. The resident reported to a staff member that the PSW on the previous shift did not check on him/her, that the call bell was not accessible, that his/her requests for assistance were unanswered, and that the PSW had been physically rough.

The health care record, call bell report and the home's investigative notes were reviewed.

Staff were interviewed and they all indicated that the home's process to contact the MOHLTC to submit a CIR is a shared responsibility. The registered nurses, the VP of Nursing Programs and the CEO and President would submit the report.

The CIR indicated that on a specified date, resident #063 informed PSW #127 of the incident, and that PSW #127 reported the incident to RPN #168.

According to information contained in the home's investigation notes:
- RPN #168 sent an email describing the incident involving a PSW and resident #063 to RPN #169 and RPN #170.
- RPN #169 forwarded the email from RPN #168 and added his own comments. RPN #169 sent the email to the VP of Nursing and copied the email to the VP of Nursing Programs, RN #171 and RPN #169.
- In the email thread, the resident worries that it will happen again tonight.

The VP of Nursing indicated in the CIR that she did not become aware of the allegation of staff to resident abuse until she reviewed the message on the following day.

As such, the licensee failed to immediately report an incident of suspected staff to

resident abuse. [s. 24. (1)]

4. The licensee failed to ensure that 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: (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.

This finding is related to Log # 032390-15 / CIR # C569-000088-15.

CIR #C569-000088-15 was submitted to the MOHLTC describing a witnessed abuse/neglect from a staff member to resident #069.

According to information contained in the home's investigation notes:
- PSW #166 who witnessed a staff member abuse resident #069 sent an email with an attached letter to the VP of Clinical Care detailing the incident.

A letter attached to the email, on a specific date, from PSW #166 was addressed to: To Whom it may concern. She indicated in the letter that she and a PSW co-worker entered resident #069's room to provide care to the resident, and that the resident while agitated hit the co-worker in the face knocking off her glasses. PSW #166 witnessed the co-worker be physically and verbally abusive to the resident. PSW #166 wrote that she did not report the witnessed abuse as she was afraid it "would affect the remainder of the shift".

A letter from the home addressed to the alleged abuser found that the actions towards resident #069 signified verbal and physical abuse, and the staff member was consequently terminated.

All PSWs interviewed indicated they are expected to report any witnessed or suspected abuse to their respective unit RPN. All RPNs interviewed indicated they report such incidents to the charge RN. The home has a scheduled designated charge RN twenty four hours a day, seven days per week. The CEO and President indicated to Inspector #549 that the RNs in the home are to complete the reporting requirements to the Director for all alleged, suspected, witnessed abuse incidents.

As such, the licensee failed to ensure the witnessed abuse to resident #069 was immediately reported to the Director. [s. 24. (1)]

5. The licensee has failed to ensure that any person who has reasonable ground to suspect that abuse of a resident has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

This finding is related to Log# 026360-15 / CIR # C569-000076-15 and Log #026316-15 / CIR# C569-000074-15.

The home submitted CIR #C569-000074-15 and CIR #C569-000076-15 on specified days. Both CIRs describe the alleged abuse of resident #065 and resident #060 by PSW #138 and witnessed by RPN #137. The CIRs included statements from both of the residents.

1. During an interview, RPN #137 indicated to Inspector #549 that on a specified day she informed the unit RN #139 of the witnessed abuse of resident #060 and resident #065 by PSW #138. RPN #137 also indicated during the same interview that on a specified day, she informed the charge RN #125 of the witnessed abuse of resident #060 and sent an email to the CEO and President, the VP of Clinical Care, the VP of Programs and the HR Manager.

Inspector #549 reviewed the reply email from the President and CEO to RPN #137, the VP of Clinical Care, the VP of Nursing Programs and the HR Manager indicating suspected emotional abuse of resident #060 and resident #065. The CEO and President indicated in the email that a Critical Incident needed to be completed.

During an interview with the VP of Clinical Care it was indicated to Inspector #549 that the home's expectation is that the RN is to submit a Critical Incident immediately when there is a report of suspected or witnessed abuse of a resident.

RN #139 became aware of the witnessed abuse of resident #060 on a specified day. CIR # C569-000074-15 was submitted six days later informing the Director of the witnessed abuse, which was not immediately.

RN #139 became aware of the witnessed abuse of resident #065 on a specified date. CIR # C569-000076-15 was submitted seven days later informing the Director of the witnessed abuse, which was not immediately. [s. 24. (1)]

6. The licensee has failed to ensure that any person who has reasonable ground to

suspect that abuse of a resident has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

This finding is related to Log # 002413-16 / CIR# C569-000005-16.

During an interview, RN #154 indicated that resident #083 informed her on a specified date that staff had hurt the resident. RN #154 indicated during the interview that she started the investigation immediately and reported the alleged abuse of resident #083 to the VP of Clinical Services.

The home submitted CIR #C569-000005-16 seven days later informing the Director of the alleged abuse of resident #083, which was not immediately. [s. 24. (1)]

7. The licensee has failed to ensure that suspicions of 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 was immediately reported to the Director.

This finding is related to Log #026165-15 / CIR #C569-000072-15.

A Critical Incident (CI) was submitted to the MOHLTC related to an incident of resident to resident physical abuse occurring on a specific date. It was reported that resident #071 acted physically towards resident #072 with no apparent trigger from resident #072. Afterwards it was found that resident #072 had injuries.

The CI was submitted more than 20 hours after the incident occurred. The incident was reported to the on-duty RN however the CI was submitted by a different RN the following day.

During an interview with Inspector #593 on March 24, 2016, RN #154 reported that she did not witness the incident between the two residents however the incident was reported to her shortly after as she was the on-duty RN.

During an interview with Inspector #593, on March 24, 2016, the VP of Clinical Care reported that it is the expectation of the home, that the on-duty RN completes the CI and submits this immediately to the Director. [s. 24. (1)]

8. The licensee has failed to ensure that suspicions of 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 was immediately reported to the Director.

This finding is related to Log #006129-16 / CIR #C569-000015-16.

A Critical Incident (CI) was submitted to the MOHLTC related to an incident of alleged staff to resident verbal abuse occurring on a specified date. It was reported by resident #079 that PSW #155 was verbally inappropriate toward resident #079 during care.

The CI was submitted to the Director more than 12 hours after the licensee was made aware of the incident.

During an interview with Inspector #593 on March 29, 2016, the VP of Clinical Care reported that the CI was submitted late to the Director as they were trying to get all of the information together and they wanted to speak to everyone involved. [s. 24. (1)]

9. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone occurred was immediately reported to the Director.

This finding is related to Log # 035918-15 / CIR # C569-000098-15.

On a specified day at a specified time, PSW #159 brought forward an allegation of staff to resident physical abuse, involving Resident #018 and PSW #158, to the VP of Nursing Programs and the HR Manager. The alleged incident occurred on the previous shift, approximately twenty four hours prior.

The HR Manager stated that PSW #159 should have reported her suspicion of abuse immediately and not at the end of her shift the following day. It was reported that PSW #159 did not receive abuse training in 2015.

The Director was not informed immediately of the suspected abuse which occurred on a specified date on a specific shift. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has 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, has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraining of resident #070 by a physical device was included in the resident's plan of care.

Observations by Inspector #593 from March 22-24, 2016, found resident #070 seated in a wheelchair with a front closing seat belt applied.

A review of resident #070's current care plan found two separate interventions documented as "loaner upright no.34 assigned with four points seat belt, able to undo" and "wheelchair with seat belt (able to undo) to be used at all times, as agreed by POA".

A review of resident #070's health care record found no documentation related to the use of a seatbelt as a restraint.

During an interview with Inspector #593 on March 23, 2016, PSW #150 reported that resident #070 was able to undo the seatbelt, however this did depend upon the time of

day as the resident started to become agitated in the afternoon and would not have the cognition to purposefully remove the seatbelt. The PSW requested to the resident to remove the seatbelt, the resident replied "no". The PSW asked again and the resident said "no". At a third request, the resident removed the napkin from his/her lap - the resident seemed confused with the request and was becoming agitated.

On March 23, 2016, at 1420, Inspector #593 requested that resident #070 undo the seat belt that was applied. The resident appeared confused with the request and was unable to undo the seatbelt at this time. At this time, a family friend who visits the resident on a regular basis reported that since the resident has had a new chair, he/she does not seem to be able to undo the seatbelt. The family member added that she has seen the resident try, however the resident seemed to have given up because he/she is unable to undo the seatbelt. The family member further reported that resident #070 has been in the new chair for approximately 3-4 weeks.

During an interview with Inspector #593 on March 23, 2016, RPN #124 reported that resident #070 now ambulated with a wheelchair as the resident was having multiple falls and that the resident knew how to open the seatbelt, so it was not considered a restraint. RPN #124 further added that she was unsure if the resident was monitored when the resident was in his/her chair with the seatbelt applied as it was not considered a restraint, therefore it may not show as a task for the PSW's on their electronic flow records.

During an interview with Inspector #593 on March 24, 2016, Restorative Services staff member #106 reported that resident #070 uses a four point belt for posture and positioning and that the resident was able to undo the belt. Staff Member #106 further added that an assessment by the Occupational Therapist (OT) was recently completed as the resident purchased a new wheelchair with an attached seatbelt. She reported that the seatbelt should be the same as the one used previously as this resident does not have a restraint, and the resident should be able to undo the seatbelt. To determine whether to restrain a resident, they would have to complete an assessment and observations over a 14 day period and then a decision is made from there. The staff member added that the RN or RPN should be initiating this assessment with any changes in the resident. The restraint is not then applied until the POA has given consent and an order has been received from the Physician for the use of the restraint.

A review of the resident #070's progress notes found an entry by the OT: "OT Data: OT met with POA today to sign ADP application and receive payment. She had no concerns regarding new light weight manual wheelchair provided and client observed to sit upright

and able to self propel with feet".

During an interview with Inspector #593 on March 24, 2016, the VP of Clinical Services reported that if the resident is unable to undo the applied seatbelt, then the seatbelt is a restraint. She added that if staff are noticing changes with this resident, they need to contact the Restorative team and complete a two week assessment of this resident to determine if the seat belt is necessary and then go from there, which included consent from the POA, an order for the use of a restraint from the Physician and updates to the written plan of care.

A review of the home's policy titled "Restraints Management Protocols- IX NSG E-15.00" last revised October, 2015, found documented that physical restraint devices include lapbelts if they are applied in such a fashion that the seatbelt opening is placed at the back of the chair and/or the seatbelt cannot be undone by the resident. [s. 31. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the restraining of residents by a physical device is included in the residents' plan of care, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe repositioning techniques when assisting resident #080 in bed.

This finding is related to Log # 027188-15 / CIR # C569-000075-15.

On a specified day, Resident #080 had a fall and sustained a injury while PSW #149 was repositioning the resident in bed.

Documentation in the progress notes that on a specified day at a specific time resident #080 fell out of bed while being repositioned by PSW staff. A post fall assessment completed on the same day identified that education was provided to PSW #149 regarding safe practices while repositioning residents in bed.

Resident #080's written plan of care for Activities of Daily Living (ADL) at the time of the incident identified that resident #080 required turning and repositioning every two hours. For transfers and toileting, it indicated that the resident required total assistance with two staff.

On March 24, 2016, PSW #147 and PSW #148 were interviewed by Inspector #573 and both indicated that resident #080 was totally dependent on staff for all aspects of ADL care, and that resident #080 required two staff total assistance for repositioning in bed.

On March 24, 2016, Inspector #573 spoke with the of VP Clinical Care who indicated that PSW #149 is a primary staff who provides direct care to resident #080. She indicated that the fall incident was due to PSW #149 failing to use safe repositioning techniques when assisting resident #080 in bed. [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 repositioning techniques, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and where the condition or circumstances of the resident require, a post fall assessment was conducted using a clinically appropriate instrument that was specifically designed for falls.

This finding is related to Log # 021904-15 / CIR # C569-000060-15.

A Critical Incident (CI) was submitted to the MOHLTC related to an incident involving resident #067 on a specified day. Resident #067 was showering independently while being supervised by a PSW and sustained a fall. An ambulance was called, and the resident was transferred to the hospital. As a result of the fall, the resident sustained an injury to a specific body part.

A review of resident #067's health care record found no documentation related to the completion of a post fall assessment.

During an interview with Inspector #593 on March 23, 2016, RPN #146 reported that when a resident has fallen, a post falls assessment is completed and can be located in the resident's electronic health care record. The RPN confirmed that this was required to be completed for every fall.

During an interview with Inspector #593 on March 23, 2016, RPN #145 reported that a post falls assessment was completed for residents who have fallen and this would be located in the electronic health care record titled "Post Fall Assessment". The RPN searched in resident #067's electronic health care record and was unable to locate a post fall assessment for the fall occurring on a specified date.

During an interview with Inspector #593 on March 24, 2016, the VP of Clinical Care

reported that a post falls assessment was required to be completed by a member of the registered nursing staff regardless of the type of fall. She further added that a post falls assessment should have been completed upon return from hospital for resident #067. It was further reported that a post falls assessment would have been required in this situation to determine if there was anything else that this resident required in their plan of care to keep the resident safe.

A review of the home's policy titled "Fall Prevention and Management - IX NSG E-11.00" last revised April, 2015, documented that if a fall occurs, the registered staff (RN/RPN) will complete a post falls assessment which includes utilizing the Fall Risk Assessment tool and establish fall risk and appropriate interventions to be taken. [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 a post fall assessment is conducted using a clinically appropriate instrument that is specifically designed for falls, when required, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of a between meal beverage in the morning.

On March 17, 2016, the following observations were made on Caravan House:

At 1028, a beverage cart was circulated and offered to the approximately thirteen residents who were in the dining area and lounge.

Five residents who were in their rooms (excluding a residents who is fed enterally and a resident who was fed breakfast in his/her room at 1000) were not offered a beverage.

On March 23, 2016, the following observations were made on Wexford House:

From 1025-1029, a beverage cart was circulated and offered to the residents who were sitting in the dining room or the lounge.

Residents #088, #089, #090, #091 and #064 were observed to be in their rooms and were not offered a beverage.

The plans of care for residents #088, #089, #090, #091 and #064 were reviewed, and there is no indication that they are not to be offered a beverage in the morning.

The PSW who offered the morning beverage confirmed that only the residents in the dining room and lounge were offered a beverage.

On March 24, 2016, the following observations were made on Donegal House.

At 1017, there were fifteen residents sitting in the dining room and lounge and six residents in their rooms. None of the residents had a beverage.

The three PSWs who were working were interviewed and all stated that they had not offered the residents a beverage this morning. At 1130, the residents had not been offered a beverage and were being brought to the dining room for lunch. [s. 71. (3) (b)]

2. The licensee has failed to ensure that the planned menu items were offered and available.

1. On March 7, 2016, the lunch meal was observed on Donegal House.

Dietary Aide, #101 showed the inspector an inventory of all of the food items to be served, and it was noted that there was only one vegetable choice which was yellow wax beans. According to the Weekly Cycle Menu garden salad was indicated as the alternate

vegetable choice, however garden salad was not offered and available to the residents on this day.

According to the Meal Production Sheet, provided to the inspector by Food Service Supervisor #122, there are thirteen residents who receive fortified potatoes at lunch. Fortified mashed potatoes were not available to the residents at lunch on March 7, 2016.

2. On March 10, 2016, at lunch, Resident #057 was served one sandwich that was cut into four quarters. The resident did not receive a vegetable with the meal. According to the menu, the vegetable options were beets or garden salad.

The resident's plan of care was reviewed and it states to provide the diet as ordered which is regular diet, regular texture. There is no indication that Resident #057 was not to receive vegetables with the meal.

A review of Resident #057's health care record indicates that the resident is assessed as being at moderate nutritional risk, is ordered an oral supplement four times daily and has been loosing weight over the past year. [s. 71. (4)]

Additional Required Actions:

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

WN #11: 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:
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).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that meals were served course by course unless otherwise indicated by the resident or the resident's assessed needs.

On March 10, 2016, resident #032, resident #003, resident #086 and resident #087 were seated at a table in the Donegal dining area. A PSW and a volunteer were providing feeding assistance to these four residents.

At 1207, Dietary Aide #100 placed dessert on the table for two of the residents who were being assisted to eat their entrees by the PSW, and then returned two minutes later with dessert for the other two residents who were being assisted to eat their entrees. At 1216, the two residents who were fed by the volunteer completed their entrees and were fed dessert. At 1224, the other two residents completed their entrees and were fed dessert.

The dietary kardex and care plans for each resident was reviewed, and there is no indication that they are not to be served course by course.

Food Service Supervisor #122 stated that all staff were expected to serve meals course by course. [s. 73. (1) 8.]

2. The licensee has failed to ensure that resident #057, resident #058 and resident #059 were served a meal only when someone was available to assist the residents.

On March 7, 2016, resident #057 was brought to the table in a wheelchair at

approximately 1210 and was served his/her meal. The resident did not attempt to feed himself/herself. At 1228, the resident had not eaten the meal, and a PSW who had been feeding two other residents at the same table moved and assisted resident #057's to eat lunch.

On March 10, 2016, at approximately 1205, it was noted that resident #057 had a sandwich on a plate that was cut into four quarters, and that the plate was pushed out of the resident's reach. At 1209, the resident was given the sandwich and ate half of one of the quartered pieces. At this time, two PSWs were sitting at the same table as resident #057, and were assisting other residents. At 1215, a PSW handed resident #057 apple juice and then water which the resident drank. At 1220, there was no one assisting at the table. At 1223, resident #057 eye's were closed and the resident appeared to be sleeping. At 1232, the resident's plate was cleared. Resident #057 had eaten half of one of the quartered pieces and had only been provided with assistance to drink at 1215. The resident was given a butter tart and fed himself/herself dessert.

A review of resident #057's health care record indicated that the resident was assessed as being at moderate nutritional risk, is ordered an oral supplement four times daily and has been loosing weight in the past year.

On March 7, 2016, resident #058 was served his/her entrée at 1208. At 1213, it was noted that the resident's head was tilted forward and his/her eyes were closed, and the resident remained this way until 1219. At 1220, twelve minutes after receiving the meal, a PSW offered the resident assistance to eat. The resident took a drink of juice and began feeding himself/herself and remained feeding himself/herself at 1241. On March 10, 2016, it was noted that resident #058 was completely fed by a friend.

A review of resident #058's health care record indicated that the resident was assessed as being at moderate nutritional risk. According to resident #058's plan of care, he/she requires extensive to total assistance with eating and receives fortified foods with meals.

On March 10, 2016, resident #059 was served his/her entrée at 1211. The resident had his/her hand supporting his/her head and appeared to be sleeping. At 1215, a PSW asked the resident why he/she was not eating but did not provide assistance or encouragement to do so.

From 1211 to 1230, resident #059 appeared to be sleeping and did not have anything to eat or drink. At 1230, the resident awoke and put his/her fork in the quiche but did not

bring it to his/her mouth. At 1231, twenty minutes after being served, a PSW asked the resident if he/she was going to eat and cued him/her to have a drink. At 1235, resident #059 had eaten half of the quiche and mashed potatoes and none of the beets when the resident was escorted out of the dining room.

A review of resident #059's health care record indicated that the resident was assessed as being at high nutritional risk, received an oral supplement three times daily and fortified foods with meals. According to Resident #059's plan of care he/she required the assistance of one person to food cut up and to provide lots of cuing, encouragement and redirection to eat. When the resident had fallen asleep, the care plan directs staff to encourage him/her to wake up and to assist the resident to eat. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that meals are served course by course and to ensure that residents who require assistance with eating or drinking are served a meal only when someone is available to provide the assistance, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents:

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected
(e) identifies the training and retraining requirements for all staff, including, (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations.

On March 22, 2016 during an interview, the VP, Clinical care confirmed to Inspector #548 that the current policy did not reflect sections (a) and (e).

The policy on abuse has not been updated since 2013. [s. 96.]

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 policy to promote zero tolerance of abuse and neglect of residents: 1. contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected. 2. identifies the training and retraining requirements for all staff, including, (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure as per O.Reg 79/10, s.110 (7) that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

5. The person who applied the device and the time of application
6. All assessment, reassessment and monitoring, including the resident's response
7. Every release of the device and all repositioning.

Resident #032 was observed on March 8, 2016 seated in a tilt wheelchair with a lap belt resting on the resident's thighs. Resident #032 was not physically or cognitively able to undo the lap belt.

The health care record for resident #032 was reviewed. Consent by the Power of Attorney (POA), a physician order and an assessment for the need of the restraint were indicated in the record.

On March 15, 2016 at 1320 and on March 16, 2016 at 1020, resident #032 was observed to be seated in a wheelchair with the lap belt applied.

On March 16, 2016 during an interview, PSW# 118 indicated that resident's #032 usual routine was to be up and placed in the wheelchair for the day by 0800 hours for breakfast, and that the resident will remain in the wheelchair for the remainder of the day. The PSW indicated that the lap belt restraint was applied while the resident was in the wheelchair at all times.

Resident #032's care plan specifies the repositioning of the resident to be implemented

every two hours, and that the restraint is to be released every hour.

A review of the documentation for resident #032 for the time period of March 2 to 14, 2016 was conducted in the presence of the Clinical Practice and Performance Coordinator. The documentation does not capture when the device was applied, released and the times the resident was repositioned from March 2, 2016 to March 14, 2015, as per the resident's daily routine and planned care.

During the time period from March 2 to 14, 2016 for resident #032, the documentation does not capture all assessment, reassessment and monitoring, including the resident's response as required with the exception of March 5, 6 and 13, 2016. This was confirmed by the Clinical Practice and Performance Coordinator who reviewed the documentation in the presence of Inspector #548. [s. 110. (7) 5.]

2. The licensee has failed to ensure as per O.Reg79/10, s.110 (7) that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

5. The person who applied the device and the time of application
6. All assessment, reassessment and monitoring, including the resident's response
7. Every release of the device and all repositioning.

Resident #003 was observed on March 8, 2016 seated in a tilt wheelchair with a lap belt resting on the resident's thighs. Resident #003 was not physically or cognitively able to undo the lap belt.

The health care record for resident #003 was reviewed. Consent by the Power of Attorney (POA), a physician order and an assessment for the need of the restraint were indicated in the record.

On March 15, 2016 at 1320 and on March 16, 2016 at 1020, resident #003 was observed to be seated in a tilt wheelchair with the lap belt applied.

On March 16, 2016 during an interview, PSW #118 indicated that resident #003's usual routine was to be up and placed in the wheelchair by 0800 for breakfast, and that the resident will remain in the wheelchair for the remainder of the day. The PSW indicated that the lap belt restraint was to be applied while the resident was in the wheelchair at all

times.

Resident #003's care plan specifies the repositioning of the resident to be implemented every two hours, and that the restraint is to be released every hour.

A review of the documentation for resident #003 for the time period of March 2 to 14, 2016 was conducted in the presence of the Clinical Practice and Performance Coordinator. The documentation does not capture when the device was applied, released and the times the resident was repositioned from March 2, 2016 to March 14, 2015, as per the resident's daily routine and planned care.

During the time period from March 2 to 14, 2016 for resident #003, the documentation does not capture all assessment, reassessment and monitoring, including the resident's response as required in O. Reg. 110(7).6 with the exception of March 6, 13 and 14, 2016. This was confirmed by the Clinical Practice and Performance Coordinator who reviewed the documentation in the presence of Inspector #548.

On March 15, 2016 during an interview with Inspector #548, RPN #116 indicated that residents with restraints were monitored hourly by the PSWs and that the PSWs were to document the application, release, repositioning and resident condition in the POC. She further indicated that registered practical nurses reassess the resident condition, response and the effectiveness of the restraint hourly and document once every eight hours that this was completed. On March 15, 2016 during an interview with Inspector #548 the Clinical Practice and Performance Coordinator confirmed the expected practice for documentation is as described by interviewed staff. [s. 110. (7) 5.]

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 every use of a physical device to restraint a resident under section 31 of the Act is documented, specifically the person who applied the device and the time of application; all assessment, reassessment and monitoring, including the resident's response; every release of the device and all repositioning, to be implemented voluntarily.

WN #14: 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 :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secured and locked.

This finding is related to Log # 002387-16 / CIR C569-000009-16.

On a specified day, RPN #132 prepared the medications of residents #068 in a paper medication cup and left it beside resident's #068's table in the dining room. PSW #133 observed resident #066 taking the medication cup and swallow it. Later on the same day, resident #066's health condition changed, and the resident was sent to the hospital.

Following the incident, RPN #132 indicated that he did not actually see resident #068 take the medications.

The medication of resident #068 were not kept secure and locked. [s. 129. (1) (a)]

2. The licensee has failed to ensure that drugs are stored in an area that is secure and locked.

On March 7, 2016, on the 2nd floor unit, Carlow house, Inspector #548 observed the

door to the medication room to be equipped with a lock, and that the lock was engaged however, the door was not latched.

The medication room is adjacent to the dining room and at the time of the observation Inspector #548 observed that there were several residents in the midst of completing their morning meal. It was observed there was no staff members present in the area. Inspector #548 entered the medication room at 1030 hours.

Inspector #548 observed that prescription and stock drugs were contained in an unlocked fridge. The prescribed drugs observed were: Insulin Glarigine 100 iu and Novorapid Pen fill Insulin Aspart 100iu for resident #041, a blue thermal pack containing three packages of Aransep for resident #042 and a box of Glycerin suppositories.

Inspector #548 observed a cupboard door equipped with a lock to be ajar. Prescription and non-prescription drugs were observed to be in the cupboard. There were two separate boxes of Scopolamine 1ml injectable vials for resident #043 and resident #044. Resident #044 had been discharged from the home several months ago.

The inspector remained in the room for approximately 10 minutes.

Upon exiting the medication room, no staff members were present and several residents remained in the dining room. The unit RPN was informed of the open door and closed and locked it. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or medication cart that is secured and locked, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 162. Approval by licensee

Specifically failed to comply with the following:

s. 162. (3) Subject to subsections (4) and (5), the licensee shall, within five business days after receiving the request mentioned in clause (1) (b), do one of the following:
1. Give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act. O. Reg. 79/10, s. 162 (3).
2. If the licensee is withholding approval for the applicant's admission, give the written notice required under subsection 44 (9) of the Act to the persons mentioned in subsection 44 (10) of the Act. O. Reg. 79/10, s. 162 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that O.Reg. 79/10 s. 162 (3) long-term care home applications for resident admissions are reviewed within five (5) business days of having received the applications from the placement coordinator.

As per O.Reg. 162. (1) Subject to sections 163 and 164, when an applicant who has been determined by a placement co-ordinator to be eligible for long-term care home admission applies for authorization of his or her admission to a particular long-term care home, the appropriate placement co-ordinator shall, (a) give the licensee of the home, in addition to the material required under subsection 44 (7) of the Act, any other information possessed by the placement co-ordinator that in the placement co-ordinator's opinion is relevant to the licensee's determination of whether to give or withhold approval for the applicant's admission to the home; and (b) request the licensee to determine whether to give or withhold approval for the applicant's admission to the home. O. Reg. 79/10, s. 162 (1).

This finding relates to Log #036238-15.

On September 1, 2015 an admission application was sent to the home from the Community Care Access Centre (CCAC) relating to applicant #073. As of March 22, 2016, the CCAC and the applicant's family had not been informed if the applicant had been accepted to the home's wait list or not.

In an interview with the Admission Clerk, she stated that she was responsible for reviewing the applications to the home. She stated that if there were any areas of concern, she referred the application to the VP of Clinical Care, otherwise the application is accepted, and the person is added to the wait list. The Admission Clerk stated that there was currently a back log of applications of approximately two hundred (200). The Admission Clerk stated that the referral status of applicant #073's application was Awaiting Response and that this meant that he/she was neither accepted or denied.

The VP of Clinical Care looked into applicant #073's application, and stated that all of the information that the home required to make a decision to accept or refuse the application was available since September 15, 2015. She confirmed that the status of the referral was Awaiting Response (from the home).

The VP of Clinical Care confirmed that the home has a large back log of applications and is aware of the legislative requirement as stated above. [s. 162. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that long-term care home applications for resident admissions are reviewed within five (5) business days of having received the applications from the placement coordinator, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

On March 10, 2016 and March 11, 2016 during an interview with Payroll/IT coordinator, and on three separate occasions requested the home's policy that deals with when doors leading to secure outside areas must be locked or unlocked, and on one occasion made the request in the presence of the VP of Maintenance.

On March 10, 2016 the Payroll/IT coordinator indicated each balcony doors on each floors automatically locks at 2100 hours each night restricting access and each assigned swipe card becomes inactive. The VP, Maintenance confirmed this.

The policy was not produced at the time of the inspection. [s. 9. (2)]

WN #17: 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 assessments.

Resident #052 required assistance with activities of daily living and spent approximately eleven hours in his/her wheelchair per day. The resident was assessed as requiring a ROHO cushion to assist with pressure management while in the sitting position.

On March 17, 2016 during an interview with the Wound Care Champion, she indicated that the home's clinically appropriate assessment tool is titled Wound Assessment 1 and is specifically designed for residents exhibiting altered skin integrity including redness, skin breakdown, pressure ulcers and skin tears. RPN #109 indicated the same. Both staff members indicated that the PSWs were expected to report any alteration in skin integrity, as confirmed by PSW #165.

The home's policy titled: Skin and Wound Care, IX NSG E-12.00, dated July 2015 is

indicated to preserve skin integrity, prevent pressure ulcers, promote comfort and mobility and prevent infection. It specifies that registered staff will "assess and complete the wound care tool in PCC when reported". During an interview with the Wound Care Champion, it was confirmed that the wound care tool in PCC is the assessment tool titled: Wound Assessment 1.

The health care record, including the progress notes were reviewed from specified dates in August 2015 to March 2016 for resident #052.

On a specified date in August 2015, the progress note entry recorded by a registered nursing staff indicated that a pressure ulcer remained to a specified body part.

On a specified date in September 2015, a progress note entry indicated that a PSW reported that there was an area of skin impairment to a specified body part.

On a specified date in September 2015, a progress note entry indicated that a specific treatment was applied to a specified body part.

On a specified date in September 2015, a progress note entry indicated that a specific treatment was applied to specified body parts.

On a specified day on October 2015, a progress note entry indicated that the resident's skin condition had deteriorated.

The Treatment Administration Record was reviewed from specified dates in August 2015 to October 2015. There is record of the administration of the prescribed treatment for the specified body part.

As such, the licensee has failed to ensure that a member of the registered nursing staff assessed the altered skin integrity exhibited by resident #052 from a specified period of time, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments. [s. 50. (2) (b) (i)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a monitoring system to measure and record each resident's height on admission and annually thereafter.

The home uses an electronic charting system (Point Click Care) and the weights and heights of the residents are recorded in a tab named Weights & Vitals.

The health care records of forty residents were reviewed, and it was noted that thirty of the forty residents did not have a height that was measured within the past year.

RPN #124 stated that resident's heights measured by the nurse within twenty hours of admission but not annually thereafter. [s. 68. (2) (e) (ii)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM was notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

This finding is related to Log #035918-15 / CIR #C569-000098-15.

On a specified day at a specified time, PSW #159 brought forward an allegation of staff to resident abuse, involving Resident #018 and PSW #158, to the VP of Nursing Programs and the HR Manager. The alleged incident occurred on the previous shift, approximately twenty four hours prior.

According to the Critical Incident Report submitted to the Director on a specified date, the VP of Nursing Programs was to contact the resident's POA on the next business day. This exceeds a 12 hour time frame. [s. 97. (1) (b)]

2. The licensee has failed to ensure that resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse.

This finding is related to Log #017421-15 / CIR # C569-000057-15.

On a specified day at at specified time, Dietary Aide #136 witnessed an incident of suspected sexual abuse between resident #061 and a visitor.

The Dietary Aide reported her suspicion to the RPN on the unit and to Food Service Supervisor #135 on the same day as the incident occurred, before the end of her shift.

The VP of Nursing Programs became aware of the allegation on the following day and began an investigation.

The resident's SDM was not notified of the suspected incident of sexual abuse until two days after the incident occurred. [s. 97. (1) (b)]

Issued on this 26th day of April, 2016

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

Original report signed by the inspector.