Ontario

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

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

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

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


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

**Division des foyers de soins de longue durée**
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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 4, 2018 | 2017_484646_0014 | 024078-17 | Resident Quality Inspection |

## Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26 Midhurst ON L0L 1X0

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

SUNSET MANOR HOME FOR SENIOR CITIZENS
49 RAGLAN STREET COLLINGWOOD ON L9Y 4X1

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

IVY LAM (646), GORDANA KRSTEVSKA (600)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): October 19, 20, 23, 24, 25, 26, 30, 31; November 1, 2, 3, 6, and 7, 2017.**

**The following intake was inspected concurrently with the Resident Quality Inspection:**
**Follow-up order intake #004322-17 related to Prevention of Abuse and Neglect,**
**Complaint inspections: #022771-17 related to Responsive Behaviours,**
**Critical Incident Inspections:**
**#024911-17 related to Falls Prevention, and**
**#024737-17 related to Prevention of Abuse and Neglect, and Responsive Behaviours.**

**During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Director of Care, General Manager, MDS RAI coordinator, Professional Standards Coordinator, Environmental Services Manager (ESM), Recreation Programs Supervisor, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Home Care Aide (HCA), 1:1 Agency staff, 1:1 Agency manager, Behavioural Support Services (BSS)-RPN, Behavioural Support Services (BSS)-PSW, Registered Dietitian (RD), Dietary Aides (DA), Program Support Services Supervisor, Activationist, Housekeeping staff, Residents, Family Members, and Substitute Decision Makers (SDM).**

**During the course of the inspection, the inspectors conducted a tour of the home, observed resident home areas, observation of care delivery processes including medication passes and meal delivery services, and review of the home's policies and procedures related to Prevention of Abuse and neglect, Responsive Behaviours, Falls Prevention, Skin and Wound Care, Minimizing of Restraining, and Nutrition and Hydration; and review of resident health records.**

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

**Falls Prevention**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **10 WN(s)**
- **7 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| LTCHA, 2007 S.O. 2007, c.8 s. 19. (1) | CO #001 | 2016_251512_0011 | 600 |
| LTCHA, 2007 S.O. 2007, c.8 s. 24. (1) | CO #002 | 2016_251512_0011 | 600 |

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

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents**
**Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,**
**(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and**
**(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.**

**Findings/Faits saillants :**

1. The home has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

This inspection had been initiated in response to a complaint (log #022771-17) related to alleged abuse by resident #021 toward multiple identified co-residents.

A review of resident #021's admission care plan indicated that the resident had been identified with responsive behaviours. The care plan indicated that the resident was triggered by noisy environments and should the resident exhibit responsive behaviours, the staff were directed to take the resident for walks to a quiet area and approach the resident from the front and remain at a safe distance.

A review of the clinical records identified that resident #021 had been assessed by the Behavioural Support System (BSS) Mobile Support Team on an identified start date. A review of BSS notes on an identified time period indicated that the resident had identified behaviours with identified triggers. The BSS recommended that the resident be provided an identified style of room accommodation, and suggested identified activities and approaches to interact with the resident.

Interview with the Program and Support Services (PSS) supervisor indicated that 1:1 staffing for resident #021 began on an identified date at an identified range of hours of monitoring, and that the hours of monitoring were increased at a later date to prevent risk of altercations between resident #021 and co-residents.

Review of resident #021's progress notes revealed several incidents of altercations between resident #021 and co-residents on a number of identified dates.

The PSS supervisor confirmed that, as per the home's records, on an identified date when resident #021 had an altercation with resident #023 at an identified home area, there was no 1:1 agency staff available and the home provided their own PSW for 1:1 monitoring for the resident. Interviews with PSWs #111, #122, and RPN #110 revealed that when the 1:1 staff are not there, the staff will monitor resident #021. RPN #110 further revealed that it is difficult for the staff to monitor resident #021 when the 1:1 is not on the unit.

Review of resident #021's plan of care did not reveal interventions related to how staff were to monitor resident #021 when the 1:1 staff was on break, or when 1:1 agency staff were not available.

Interview with Registered Practical Nurse (RPN) #110 revealed that at the time of the altercation that occurred on a subsequent identified date, where resident #021 demonstrated responsive behaviours toward resident #008, the 1:1 agency staff was having his/her break. RPN #110 was not able to relay if the 1:1 staff had notified the registered staff that he/she was going on break at the time.

Interviews with PSW #122, 1:1 agency staff #139 and #138 revealed that an identified approach was used with resident #021. Further interviews with PSW #122, RPN #125, and the Director of Care (DOC) revealed that having the 1:1 available with resident #021 was an effective intervention in assisting residents. Interview with PSS supervisor and RPN #110 revealed that there were times when coverage for when the 1:1 agency staff was not available. Interviews with RPN #110, RN #136, and the DOC revealed that there were no directions developed and implemented at the times of the abovementioned incident for when the 1:1s would go on break, and no planned communication process between agency and home staff for when 1:1 agency staff specific for resident #021 was not on the unit, to ensure continued monitoring of resident #021.

Further, the registered staff, Professional Standards Supervisor and the DOC revealed that the interventions to minimize the risk of altercations and potentially harmful interactions between resident #021 and co-residents were not developed or implemented during the abovementioned incidents when the 1:1 staff specific for resident #021 was not available for the resident, or was not with the resident. [s. 54. (b)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,**
**(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).**
**(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).**

**Findings/Faits saillants :**

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

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date, related to an incident that caused an injury to a resident for which the resident was taken to a hospital and resulted in a significant change in the resident's health status. Review of the CI report indicated on an identified date, at an identified time, Registered Practical Nurse (RPN) #137, found resident #016, on a floor in an identified resident area. On assessment, the resident complained of pain but did not specify the area. After the assessment the resident was transferred to a bed and when the RPN and Personal Support Worker (PSW) #141 tried to reposition resident #016 to provide an identified care, the resident complained of pain on an identified area of the body.

The physician was notified and he/she ordered transfer to the hospital for further assessment.
An identified injury on an identified part of resident #016's body was confirmed while in hospital, and the resident's condition deteriorated.

The health team decided to transfer the resident to a hospice for palliative care and symptoms management. The resident passed away on an identified date.

Review of resident #016's falls risk assessment record revealed the resident was assessed on an earlier identified date, and had been identified to be at high risk for falls. Review of the post fall huddle for last quarter in 2017, revealed that resident had fallen an identified number of times a month prior to the assessment, four times in an identified resident area, once from his/her identified mobility device, and twice trying to provide an identified care for himself/herself in an identified resident area.

The resident also had fallen off an identified mobility device in an identified resident area on an identified date, and again fell off the same mobility device in another identified resident area on another identified date. The fall that he/she sustained at the time of the reported CIS, was the last fall when staff found the resident had fallen off the bed in an identified resident area and sustained injury for which he/she was sent to the hospital.

Review of Minimum Date Set (MDS) dated two months prior to that fall, revealed resident #016 had identified memory problems and cognitive impairment. The resident was assessed at an identified level of continence and required an identified level of assistance for bed mobility, transfer, toilet use, personal hygiene, dressing, eating, and locomotion. Further, the MDS revealed that the resident's physical condition had deteriorated as compared to status of the previous assessment. The MDS also revealed that the resident had a fall in a past 30 days as well as fall in past 31 to 180 days. Resident was on a number of identified medications for his/her conditions.

Review of resident #016's Resident Assessment Protocol (RAP) on an identified date revealed that the resident continued to be at risk for fall related to use of his/her identified medication, increased weakness, unsteadiness on his/her feet and identified changes in weight. The planned goal was to minimize risks and maintain resident #016's safety.

Review of the resident's written plan of care on an identified date, revealed that the goal for safety of the resident's needs was to provide safety and security over the next

quarter.

Under falls risk strategies the interventions were staff to take the resident to the toilet if he/she is exhibits an identified type of responsive behaviours, to be monitored, and the bed to be to the lowest position and to be locked.

Interview with PSW #140 confirmed that the directions in the resident's written plan of care were not clear as to when and for how long to monitor the resident, or should PSW toilet the resident #016 only when he/she exhibited the identified responsive behaviour, how would find out if the resident was exhibiting the identified behaviour.

Interview with RAI-MDS Coordinator #133 confirmed that the plan of care did not set out clear directions to staff who provide direct care to the resident how to prevent the resident from falls. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs had changed.

A CIS report (intake #024737-17, associated intake #012312-16) was submitted to the MOHLTC on an identified date for alleged resident to resident abuse.

Review of the CIS report indicated on an identified date, resident #014 was sitting in the lounge in front of the nursing station, talking with a co-resident. The co-resident revealed to the staff that resident #015 interacted with resident #014, then sat down leaned over him/her and caused an identified injury to a part of his/her body. The residents were separated immediately and support given to both residents post-altercation. The CIS further revealed that resident #015 had history of identified responsive behaviours and the home took measures to address his/her responsive behaviour. The CIS review did not indicate whether or not resident #014 experienced any responsive behaviour.

Review of the resident's progress notes on the identified date of the incident revealed RPN #110, who was just coming around the corner, witnessed resident #015 caused an identified injury to an identified part of resident #014's body, and the RPN separated the residents. Further, the notes revealed that resident #014 stated to the RPN that resident #015 committed the identified injury to one identified part of his/her body, but did not recall if he/she also did it to the other identified part of the body. The resident also stated that resident #015 committed another injury to another identified part of his/her body.

Resident #015 was unable to be interviewed at that time.

Review of resident #014's MDS record on an identified date prior to the incidents, revealed that the resident was at an identified level of cognitive impairment. The resident had identified mood and behaviour patterns during the observation period, and had been easily distracted.

Review of the resident's progress notes for the identified quarter period within and after the MDS assessment was completed, indicated resident #014 had exhibited responsive behaviour towards other residents on several identified occasions:

- On an identified date at an identified time, resident #014 took away a co-resident's identified beverage insisting that the beverage belonged to another co-resident. The first co-resident became upset and he/she took the beverage back. Further, the notes indicated resident #014 interacted negatively toward the first co-resident.

- On a subsequent identified date at an identified time, resident #014 was leaving an identified resident area and crossed paths with resident #015. Resident #014 interacted negatively toward resident #015, and triggers were not identified. Family redirected the resident, and triggers were not identified.

Six other incidents on separate identified dates with negative interactions between resident #014 were identified where issues were identified with the home's response, including:

- On the first incident, no documentation of staff interventions and outcome of the incident;
- On the second incident, triggers of the responsive behaviour not identified and no documentation regarding the consequences, interventions or the outcomes;
- On the third incident, no intervention applied and the outcome was not noted;
- On the fourth incident, documentation failed to reveal if any intervention was applied, with the only intervention being that staff will monitor;
- On the firth incident, the resident spoke with a co-resident who was asleep and did not respond to the resident, which resulted in further agitation of resident #014;
- On the sixth incident, the staff had identified that resident #014 exhibited identified responsive behaviours

Subsequent to those behaviours, co-residents became angry and reacted. The triggers

for resident #014's responsive behaviours were not identified. Staff interventions were to reassure the resident and advise to be polite to co-residents. The progress notes did not indicate what the outcome was. Each encounter was unprovoked. No consequences, intervention or outcome was noted.

Review of the most recent MDS assessment on an identified date revealed resident #014 still experienced identified responsive behaviour up to five days weekly within 30 days observation period. Observation within the seven days prior the assessment indicated that resident had experienced other identified behavioural symptoms from one to three days.

Review of resident #014's plan of care and the assessment record for an identified period in time, failed to reveal that resident #014 had been assessed, or reassessed for expressing identified responsive behaviour towards other residents, the triggers for such a behaviour had not been identified and there was no plan as to how to manage resident #014's identified responsive behaviours.

Interview with RPN #110, PSW #126, Registered Nurse (RN) #118 confirmed that resident #014 had been expressing responsive behaviour towards other residents and towards the staff. The RPN and the PSW stated that the resident was like that and he/she did not mean to harm anyone.

The interview with both registered staff confirmed that the resident was not assessed or reassessed and the triggers were not identified for when the resident was expressing responsive behaviour, therefore no plan of care to manage the behaviour was put in place. Interview with the Professional Standards Supervisor confirmed that there was no evidence that the staff assessed or reassessed the residents experiencing responsive behavior and the staff did not identified his/her behaviour as a trigger for other residents' responsive behaviour. [s. 6. (10) (b)]

3. The licensee has failed to ensure that if the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care.

A CIS report was submitted to the MOHLTC on an identified date for an incident that caused an injury to a resident for which the resident was taken to a hospital and which resulted in a significant change in the resident's health status. Review of the CI report indicated on an identified date, RPN #137 found resident #016, on the floor in an

identified resident area. On assessment, the resident complained of pain but did not specify an area specific area. After the assessment, the resident was transferred to his/her bed. When the RPN and PSW #141 tried to reposition resident #016 to provide an identified care, the resident complained of pain to an identified area of his/her body. The physician was notified and he/she ordered transfer to the hospital for further assessment. An identified injury to an identified area of the body was confirmed at the hospital, and the resident's condition deteriorated, and the health team transferred the resident to a hospice for palliative care and symptoms management. The resident passed away on a later identified date.

Review of resident #016's falls risk assessment record revealed the resident was assessed on an identified date to to be at high risk for falls. Review of the post fall huddle for last quarter in 2017 revealed that resident had nine falls on identified dates in a four-month period.

Review of the resident's MDS on an identified date, revealed resident #016 was at an identified level of cognitive impairment. The resident was also at an identified level of continence, and required an identified level of assistance for bed mobility, transfer, toilet use, personal hygiene, dressing, eating, and locomotion. Further, the MDS revealed that the resident's physical condition had deteriorated as compared to status of the previous assessment. The MDS also revealed that the resident had a fall in a past 30 days as well as falls in past 31 to 180 days. Resident was on an identified number of medications for his/her health conditions.

Review of resident #016's Resident Assessment Protocol (RAP) on an identified date, revealed that the resident continued to be at risk for fall related to use of an identified class of medications, increased weakness, unsteadiness on his/her feet and weight changes. The planned goal was to minimize risks and maintain resident #016's safety.

Review of the resident's history of plan of care revealed that after resident #016 had been reassessed for falls prevention, but there were no different approaches considered in the revision of the plan of care. The same interventions were maintained regardless of the reason of falls.

Interview with PSW #141 revealed that the was at a certain level of mobility before and staff were to monitor him/her every time when they were walking around, and continued to monitored him/her after his/her condition had deteriorated. Further, the PSW indicated that they were aware of the interventions to monitor on him/her and to offer him/her

assistance with toileting like they always had been doing.

Interview with RN #119 confirmed that when resident #016 was reassessed after the falls but the staff did not revise the plan of care for the effect of the interventions and did not consider different approaches to prevent the resident from falls. [s. 6. (11) (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:***
***1) the written plan of care for each resident provides clear direction to staff and others who provide direct care to the resident,***
***2) the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs had changed, and***
***3) if the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails**

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

**s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
**(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
**(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
**(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that where bed rails were used, that residents were assessed in accordance with prevailing practices to minimize risk to the resident.

During the resident observation in stage one of the Resident's Quality Inspection (RQI), one bed side rail was observed in "up" position for resident #001. Staff interview in stage one of the RQI inspection revealed that the side rails had been used for this resident and the resident was not physically capable of getting out of bed on his/her own.

Review of resident #001 MDS assessment on a specified date revealed that the resident was identified at a specified level of cognitive impairment, as well as a specified sleep pattern, physical movements, and needed a specified level of assistance from staff for bed mobility, and received specified medications daily. Interventions listed in resident's plan of care included keeping the resident's bed at a specified height, with both side rails engaged and hand controls locked out at all times for safety.

Interview with RPN #102 revealed that the resident has two specified type of side rails applied for safety. [s. 15. (1) (a)]

2. During the resident observation in stage one of the RQI, one bed side rail was observed in the "up" position for resident #003. Staff interview in stage one of the RQI inspection revealed that the side rails had been used for this resident and the resident was not physically capable of getting out of bed on his/her own.

Review of the resident's MDS assessment record on a specified date revealed that resident was at a specified level of cognitive impairment, needed specified level of assistance by a specified number of staff for bed mobility, and was at a specified level of ability for walking. The resident's plan of care included a specified bed at a specific height, and bed rails on a specified side of bed in place.

Interview with PT #154 revealed that the resident had one specified side rail applied when in bed for safety, as the resident was at risk for fall. [s. 15. (1) (a)]

3. During the resident observation in stage one of the RQI, one bed side rail was observed in the "up" position for resident #004. Staff interview in stage one of the RQI inspection revealed that the side rails had been used for this resident and the resident was not physically capable of getting out of bed on his/her own.

Review of resident MDS assessment revealed the resident was at a specified level of

cognitive impairment, and need a specified level of assistance for bed mobility, and had a specified number of side rails in place.

Interview with RN #102 revealed that resident has a specified number and type of side rails applied, the resident was not able to go in or out of bed by herself, and the rails are there for safety.

According to prevailing practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), residents are to be clinically assessed by an interdisciplinary team, over a period of time, while in bed, by answering a series of questions to determine why bed rails would be needed (either as a restraint or a device to assist with bed mobility and transfers) and if bed rails are a safe option for their use.

The assessment guideline offers examples of key assessment questions that guides decision-making such as the resident's history of falls from bed, previous bed rail use, communication limitations, their mobility, cognition status, involuntary body movements, their physical size, pain, the resident’s medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors and the entrapment status of the resident’s bed. The assessment guideline also emphasizes the need to document clearly whether alternatives to bed rails were used (soft rails or bolsters, perimeter reminders, reaching pole) and if they were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. The final conclusion, with input from either the resident or their SDM (Substitute Decision Maker) and other interdisciplinary team members, would be made about the necessity and safety of bed rail use for a particular resident and the details documented on a form (electronically or on paper). The details would include why one or more bed rails were required, the resident's overall risk for injury, suspension or entrapment, permission or consent (from either the SDM or resident), the size or type of rail to be applied (rotating assist rail, fixed assist rail, 1/4, 1/2 or 3/4 bed rail), when the rails are to be applied (at night only, when requested by resident or with staff assistance), how many bed rails (one, two or four), on what sides of the bed and whether any accessory or amendment to the bed system is necessary to minimize any potential injury or entrapment risks to the resident.

The licensee's clinical assessment process of residents using bed rails was compared to the assessment guidelines and was determined to lack in several key components, and

was, therefore, not developed in accordance with prevailing practices as identified in the above assessment guideline.

The licensee's two policies related to bed safety were reviewed and included "Safety, Security and Risk Management-Restraints" #NPC G-75 dated November 2016, and "Safety, Security and Risk Management-Entrapment" #NPC F-05 dated June 2017.

As part of the home’s process in assessing the resident, the RNs were directed by their "Safety, Security and Risk Management-Restraints" policy to use a form titled “Side Rails and Alternative Equipment Decision Tree” and the procedure included “yes” and “no” decisions. No specific information was included to define how the resident’s safety while in bed was to be completed. The procedures did not include how long the resident would be observed while in bed (with and without bed rails), the length of time resident’s would be monitored with or without bed rails, what alternatives need to be trialled before deciding that bed rails are an ideal option and for how long, who would monitor the resident during the night and how often, what specific hazards would be monitored for and subsequently documented and how specifically other team members would participate in assisting the RN in making a final decision about the benefits versus the risks of the resident's bed rail.

The licensee’s policy titled "Safety, Security and Risk Management-Entrapment" focused on ensuring that the residents’ beds were in good condition, passed all zones of entrapment and were inspected on a regular basis.

The policy did not identify how consent would be acquired from the resident or SDM to apply the bed rails and did not identify exactly what information needed to be shared with the SDM or resident with respect to bed rail hazards.

The “Side Rails and Alternative Equipment Decision Tree” form, which was not listed under required assessment to be used upon admission (or with any change in status), was not designed to document what bed related risks were monitored for after admission. The questions included is the resident able to make a decisions independently, does the resident have a preference for using one quarter side rail, functional capacity to roll or reposition self in bed, does the resident require side rails for transfer or bed mobility, ability to get in and out of bed without staff assistance, does resident attempts to get out of bed unsafely, is resident immobile. These questions, when answered with “yes” or “no” were completed and placed in resident’s chart.

The form did not include a section that included information to assist decision making around the hazards of bed rail use. Examples of questions include but are not limited to bed rail injuries (banging into or against the rail), sleeping habits (if the resident was restless, frequently exited the bed, was in pain, had a sleep disorder, hallucinations, delirium, slept next to a rail, or along edge of bed), if body parts went through the rail, if the resident understood the purpose of the bed rail or knew how to apply it independently, if the resident knew how to use other bed related components such as a bed remote and their bed mobility and transfer capabilities.

No information was available in the licensee's policies regarding when and how often the resident to be assess and re-assess for using bed rails and the use of bed accessories or attachments such as bed remote controls for residents that may have some cognitive deficits.

Review of resident #001, #003, and #004's admission assessment, the form "Side Rails and Alternative Equipment Decision Tree" was not included. No alternatives were documented as trialled before applying the bed rails.  Interview with Physiotherapist (PT) #154revealed that the PT is having a role in assessing the resident's transfer capabilities (in and out of bed) and their general mobility status and the PSWs provided information about the residents' abilities to reposition themselves in bed and their overall activities of daily living (sleeping, eating, dressing, toileting, pain, falls, communication etc.) but the registered staff is making decision.

The staff roles identified and to what extent their input would assist the RN in making decisions about the residents' overall bed safety risks was not included in either of the bed related safety policies.

Second interview with RPN #102 revealed that usually the RN on admission creates the resident's plan of care and enter for side rails to be used, and the staff would follow the guidelines from the written plan of care.

Interview with RN #118, the admission RN confirmed that on admission he/she collects information from the CCAC records, previous homes' records, or the family members, and create plan of care for the resident of using side rails. If there is no indication for using side rails, he/she does not create plan of care. The RN confirmed that he/she does not assess the resident for using side rails.

Interview with the Professional Standards Supervisor confirmed that the home does not

assess the resident for using side rails unless they are applied as a restraints or PASD. [s. 15. (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 where bed rails were used, that residents were assessed in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the residents were protected from abuse by anyone.

A CIS report was submitted to the MOHLTC on an identified date related to alleged resident-to-resident abuse.

Review of the CIS report indicated on an identified date, resident #014 was sitting in a specified resident area, and was talking with a co-resident. After the incident, the co-resident confirmed with the staff that resident #015 had an altercation with resident #014 to a specified area of his/her body, then sat down performed another altercation to another part of resident #014's body. The residents were separated immediately and support given to both residents post-altercation. In the analysis and follow up section, the CIS revealed that resident #015 had a history of responsive behaviour and the home took measures to address his/her responsive behaviour. The CIS review did not indicate if resident #014 had any responsive behaviour.

Review of the resident's progress notes revealed that RPN #110, who was coming around the corner at the time of the incident, had witnessed resident #015's altercation with resident #014's, and he/she ran to separate the residents. Further, the notes revealed that resident #015 stated to the RPN that he/she had the altercation with resident #014, and that resident #105 had performed the altercation, but was not able to recall if he/she had attempted any altercations with resident #015 at the time of the incident. Resident #014 was also able to recall the incident of altercation by resident #015. Resident #015 was unable to be interviewed at that time.

Review of resident #014's MDS record on a specified date before the incidents occurred revealed that the resident had an identified memory problem and an identified level of cognitive impairment.

Review of the resident's progress notes on the date of the incident revealed that resident #014 was sitting at an identified resident area with co-resident and talking. The co-resident confirmed to the staff that resident #015 had confirmed with the staff that resident #015 had an altercation with resident #014 to a specified area of his/her body, then sat down performed another altercation to another part of resident #014's body. Resident #014 sustained an identified injury from the altercation.

Interview with RPN #110, PSW #126, RN #118 confirmed that resident #015 had been experiencing identified responsive behaviour and he/she had been followed by the BSO team. The interview with both registered staff confirmed that the resident #014 was abused by resident #015.

Interview with the Professional Standards Supervisor confirmed that resident #015 was physically abusive towards resident #014 and the home did not identified resident #014's behaviour as a trigger for other residents' responsive behaviour, and that the residents were not protected from abuse by anyone. [s. 19. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

This inspection was initiated in response to a complaint (log #022771-17) received on an identified date related to alleged abuse by resident #021 toward multiple identified co-residents, including resident #024.

Review of the home's policy, titled 'Zero Tolerance of Abuse and Neglect' (Policy number ADM F-10, Effective date: April 2017), revealed that the Home will notify the resident's SDM immediately upon the Home becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in physical injury or pain to the resident.

The policy further revealed that all staff, volunteers, contractors and affiliated personnel are required: 1) To fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the MOHLTC, and 2) To

immediately report to the RN in the home on duty (or on call) at the time of a witnessed or alleged incident of abuse or neglect.

The policy further revealed that management staff investigating the incident must investigate immediately all reports of abuse or neglect, including documenting the evidence appropriately, and completing the documentation of all known details of the reporting incident. The policy further details that a report shall be made to the MOHLTC Director with the results of every investigation conducted under this policy and any action the Home takes in response to any incident of resident abuse or neglect.

Review of the progress notes for residents #021 and #024, and pointclickcare incident report revealed that on an identified date, resident #021 entered an identified home area and had an altercation with resident #024. After the incident, the home's assessment revealed an identified injury on an identified part of resident #024's body, and this was further documented in the progress note.

The home's pointclickcare incident report on the abovementioned date did not reveal that the management or any other persons were notified of the incident.

Review of the progress notes revealed that RPN #125 had called RN #136, and the RN had documented regarding the incident in the progress notes.

Interview with RPN #125 revealed that it was the responsibility of the registered staff to notify the family about the incident, but on the day of the September incident, he/she was called to another incident and had not informed the family.

Interview with RN #136 revealed that it is the RNs who begin the CIS reports to the MOHLTC, but that he/she had not submitted the CIS as he/she was not aware that there was an injury to the resident, and that he/she also did not inform both residents' SDMs of the incident.

Interview with the DOC revealed that it was the home's expectation for staff to comply with the home's zero tolerance of abuse and neglect policy. The DOC further revealed that the staff should have immediately informed both the residents' SDM upon becoming aware of the incident of abuse that has resulted in an injury to the resident, and that the staff should have reported the MOHLTC director immediately. [s. 20. (1)]

2. This inspection had been initiated in response to a complaint (log #022771-17)

received on an identified date, related to alleged abuse by resident #021 toward multiple identified co-residents, including resident #008.

Review of the home's policy, titled 'Zero Tolerance of Abuse and Neglect' (Policy number ADM F-10, Effective date: April 2017), revealed that the Home will notify the resident's SDM immediately upon the Home becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in physical injury or pain to the resident.

The policy further revealed that staff must immediately report every alleged, suspected, or witnessed incidents of abuse of a resident by anyone; that staff must investigate immediately all reports by staff under this policy; and a report shall be made to the MOHLTC Director with the results of every investigation conducted under this policy and any action the home takes in response to any incident of resident abuse or neglect.

Review of resident #008 and #021's progress notes revealed that on an identified date, PSW #122 had observed resident #021 had an altercation with resident #008. PSW #122 attempted to calm resident #021 and RPN #110 also came to assist and separate both residents.

RPN #110's progress notes on the day of the incident further revealed that resident #021's 1:1 staff was on his/her break at the time of the incident.

Review of resident #008's records did not reveal any skin assessments done on the day of the incident. Resident #008's progress notes the day after the incident revealed that RN #137 attempted to assess the resident for identified injuries from the incident the previous day, but resident #008 refused to be assessed at that time. RN #137 further called to notify resident #008's family regarding the incident, and that he/she was not able to assess the resident for any injuries.

Review of resident #008's progress notes revealed that PSW #111 noticed several new identified types of injuries on resident #008's identified part of the body two days after the incident, and the PSW documented it was possibly due to the altercation with resident #021 on the abovementioned incident.

Interview with PSW #111 revealed that he/she would chart any incidents of negative interactions on the progress notes, or any injuries, and would notify the RPN. The staff were unable to identify any further records of the incident after the injury was identified.

The registered staff were not able to recall if they had been informed by PSW #111 of the injury.

The home was unable to find records of incident reports on the abovementioned incident. No record for contacting resident #008's SDM was found after the injury was identified. The MOHLTC Director was not notified of the abovementioned incident.

The DOC revealed that it was the home's expectation for the staff to immediately inform both the residents' SDM upon becoming aware of the incident of abuse that has resulted in an injury to the resident, the registered staff should have attempted to reassess resident #008 at a later time after the initial refusal, and that the staff should have reported the MOHLTC director immediately. The DOC further revealed that it was the home's expectation for staff to comply with the home's zero tolerance of abuse and neglect policy. [s. 20. (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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.***

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

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

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

**Findings/Faits saillants :**

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

During stage one of the RQI, resident #007 was triggered by the MDS for altered skin integrity in the most recent MDS assessment.

Review of resident #007's MDS assessment on an identified date revealed the resident had two alterations of skin integrity to an identified part of his/her body. Review of the resident’s MDS on another identified date revealed that one of the alterations to skin integrity had worsened.

Review of resident #007's clinical assessment record revealed that the resident did not have weekly wound assessment record for an identified period of a month, when the condition of the identified alteration of skin integrity had been identified in the MDS assessment as worsened.

Interview with RPN #153 revealed that when residents developed the identified type of altered skin integrity, the practice in the home was to assess the resident’s altered skin integrity every week using the wound assessment tool specifically designed for wound assessment. Further, the RPN confirmed that for the time specified for missing the assessment records, he/she had been away. The RPN also confirmed that there was no indication that the resident had been reassessed for that period of time which, eventually contributed for the worsening of one of the identified altered skin integrity for resident #007.

Interview with the RPN #110 revealed that he/she applied the treatment on the resident's alteration of skin integrity and documented in the progress notes, however the RPN indicated that he/she did not reassess the resident for the identified period, as he/she thought the evening nurse will do the assessment.

Interview with the DOC confirmed that the staff is trained and expected to reassess the resident with the identified alteration in skin integrity on weekly basis using the clinically appropriate tool designed for this. [s. 50. (2) (b) (iv)]

***Additional Required Actions:***

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

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

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

**s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

During an interview, inspector observed PSW #111 take a prescribed type of medication out of his/her pocket and handed to a staff from an upcoming shift. Interview with the PSW revealed that he/she was to provide the identified type of medication to resident #032 before the end of his/her shift because the resident refused care that morning and the PSW was not able to provide the identified medication earlier. At the initial interview the PSW stated that RPN #110 had given the identified prescribed medication in the morning and explained everything about the medication that the PSW needed to know.

Interview with RPN #110 revealed that he/she did not delegate any prescribed medical treatment to PSW #111 or any other PSW.

Interview with RPN #112 confirmed that the RPNs are to provide prescribed medication to the resident and is not to be delegated to the PSW or to be left in residents' rooms.

The second interview with the PSW confirmed that the identified prescribed medication was on resident #032's bedside table in the morning and the PSW picked it up from there. Further, he/she confirmed that the usual routine for residents who refused care was to have the identified prescribed medication available with PSW and when the resident agree to an identified care, the PSW would provide the identified medical treatment right away.

Interview with RN #118 confirmed that the home does not delegate prescribed medication and medical treatments to the PSWs. [s. 131. (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 no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse, to be implemented voluntarily.***

**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

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

**s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,**
**(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).**
**(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).**
**(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed
(b) corrective action is taken as necessary, and
(c) a written record is kept of everything required under clauses (a) and (b).

During the inspection of the medication administration IP, review of Medication Incident Records of 2015, 2016, and 2017, revealed that home used electronic medication incident recording in 2017, created by the pharmacy, titled MEDeRecord – Medication Incidents 2017, for reporting any medication incident in the home regardless if it is pharmacy error or staff error during the medication administration.

Review of the medication incident record revealed that in 2017, there were an identified number of reported medication incidents which were categorized by stage and by type. Further review of the records revealed that in the first month there were three incidents of medication administration for incorrect dose, incorrect medication and incorrect time. In the second month, one incident of order entry/transcription, three incidents of dispensing/delivering, and three incidents of medication administration for incorrect dose three, incorrect medication two and incorrect time one. In the third month were reported two incidents of dispensing/delivering and medication administration for extra dose and incorrect medication. In the fourth month, one medication incident was reported for dispensing an extra dose. In the fifth month, was reported incident of medication administration for incorrect resident and change of medication. In the sixth month, three

medication incidents were reported for an incorrect and an omitted dose, under order entry/transcription, dispensing/delivery and medication administration.

In the seventh month, four medication errors of order entry/transcription, dispensing and medication administration for incorrect medication, incorrect dose and omitted dose were reported. In the eighth, five medication incident were reported of dispensing and medication administration for incorrect dose, three and incorrect medication, two incidents. The ninth month had six medication incident reports of dispensing and medication administration for incorrect time, extra dose and omitted medication. Review of the medication incident record also revealed that the incident conducted by the pharmacy had review, analysis and the action plan, however, the medication incident performed by the staff of the home had not been reviewed, analyzed or developed an action plan to prevent further occurrence.

Interview with the DOC revealed that he/she was not able to provide more information about the medication incidents record prior his/her arrival in the home. The interview with DOC indicated that the medication incident report have been discussed on each Professional Advisory Committee meeting but the DOC had not reviewed, analyzed and provided an action plan to prevent further occurrences.

Interview with the Professional Standards Supervisor confirmed that the expectation of the home is every incident to be reviewed, analyzed and corrective action to be taken as needed as soon as the incident occurs. [s. 135. (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) all medication incidents and adverse drug reactions are documented, reviewed and analyzed,***
***(b) corrective action is taken as necessary, and***
***(c) a written record is kept of everything required under clauses (a) and (b)., to be implemented voluntarily.***

**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

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

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home: been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately.

This inspection had been initiated in response to a complaint (log #022771-17) received an identified date, related to alleged abuse by resident #021 towards multiple identified co-residents, and of concerns regarding the home's response to his/her complaints.

Interview with the complainant revealed that he/she had notified the home's staff and management, by phone and in-person, of his/her ongoing concerns regarding the safety of residents on an identified home unit due to resident #021's responsive behaviours toward co-residents on the unit, since an identified date.

A number of identified incidents that he/she had reported were provided by the complainant. The complainant further revealed that he/she had voiced a complaint to the home's management on an identified date after witnessing an altercation between resident #021 and resident #008, and that his/her complaints are still not resolved.

Review of the home's policy titled, 'Complaints Procedure' (Policy number ADM D-10; effective date January 2015), revealed that:
- When staff receive a complaint, they are to immediately address or correct the situation if possible and inform the departmental Manager/Supervisor of the issue. The Manager/Supervisor will forward the complaint via the complaints email, with notifications going to the Administrator, Director of Resident Care, Nurse Manager of Performance Quality & Development, and the Quality & Development Coordinator.

Interview with PSW #117 regarding one of the identified incidents on an identified date revealed that he/she was informed by the family member of resident #026 that resident #021 had an identified altercation with resident #023 in an identified home area.

Interview with PSW #122, and RPN #110, regarding the incident on another identified date, revealed that the family member of resident #026 had observed the incident and had attempted to intervene an altercation between residents #021 and #008. Both PSW and RPN further revealed that the family member had shown them that he/she had sustained an identified injury himself/herself during the incident from resident #021.

Interview with the DOC revealed that the staff should have followed the home's Complaints policy to inform the appropriate registered staff and managers when family members have complaints about residents' care, to ensure that the management are aware of the incidents, and to follow the appropriate steps in dealing with complaints as per the home's written procedures. [s. 101. (1) 1.]

2. This inspection had been initiated in response to a complaint (log #022771-17) received on an identified date related to alleged abuse by resident #021 toward multiple identified co-residents, and of concerns regarding the home's response to his/her complaints.

Review of resident #021's admission care plan for responsive behaviours at an identified period of time revealed that the resident exhibited identified responsive behaviours toward staff and residents.

Review of resident #021's progress notes from PSW #126 revealed that on an identified date, resident #021 exhibited identified responsive behaviours toward other residents, and residents were showing fear of resident #021. The progress notes further detailed that resident #028's family member told PSW #126 that he/she was very concerned for his/her family member and the other residents after observing resident #021 at an identified time period. The PSW reassured the family members that he/she would 'write (his/her) concerns down', and suggested for the family member to speak with the RPN.

Review of the home's policy titled, 'Compliments, Recommendations or Concerns,' (Policy number: ADM D-05; Effective date: January 2015), revealed:
'Concern' is defined as "written, spoken, or electronic statement in which someone expresses worry about an aspect of resident care and services provided in the home," and "this is generally able to be readily resolved internally."

Procedures included:
- Residents or their representatives can bring forward compliments, recommendations or concerns by speaking directly to the RPN charge nurse on the unit, the RN in charge of the building, the department manager, the Director of Resident Care or the Administrator,
- Completing the "We Care What You Think" form and submitting to the Administrator
- All concerns received, shall be acknowledge as soon as possible by the staff receiving them, and are to be communicated to the manager of the department and acted upon immediately.
- All managers receiving a compliment, recommendation, or concern from a resident or representative shall record them on the Compliments, Recommendations and Concerns (CRC) Log

Interview with the PSW #126 revealed that he/she had communicated to the RPN about the family's concern, but it was not documented in the progress notes. The PSW was not able to recall the RPN whom he/she had informed.

Further interview with PSW #126 revealed that if residents or family members voiced concerns or complaints about a resident, he/she would talk to the family, document the concerns on progress notes, and let the RPN know.

Interview with RPN #110 revealed that he/she would create a risk management incident report as abuse, and let the RN know. Interview with RN #136 revealed that he/she would document the conversation, and would email the DOC or administrator if he/she determined it was serious.

Interviews with PSW #126, RPN #110, and RN #136, revealed that they were neither aware of the "We Care What You Think" form, nor were they aware of the Compliments, Recommendations and Concerns Log.

Interview with the DOC revealed that the abovementioned incident would be considered a concern, and it was the home's expectation for the PSW to not only encourage the family to let the registered staff know of their concern, but also the PSW should inform the registered staff of the concern himself/herself. The DOC further revealed that the staff should have followed the home's Compliments, Recommendations or Concerns policy to inform the appropriate registered staff and managers as per the written procedures. [s. 101. (1) 1.]

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

This inspection had been initiated in response to a complaint (log #022771-17) received on an identified date related to alleged abuse by resident #021 toward multiple identified co-residents, and of concerns regarding the home's response to his/her complaints.

Interview with the complainant revealed that he/she had notified the home's staff and management, by phone and in-person, of his/her ongoing concerns regarding the safety of residents on an identified home unit due to resident #021's responsive behaviours toward co-residents on the unit, since an identified period in time.

He/she further revealed that he/she had voiced a complaint to the home's management on an identified date after witnessing an altercation between resident #021 and resident #008, but had not received a response from the home until 11 business days after the initial complaint, to arrange to meet regarding her concerns. The complainant further expressed that his/her complaints are still not resolved.

Review of the home's policy titled, 'Complaints Procedure' (Policy number ADM D-10; effective date January 2015), revealed that:
- When staff receive a complaint, they are to immediately address or correct the situation if possible and inform the departmental Manager/Supervisor of the issue. The Manager/Supervisor will forward the complaint via the complaints email, with notifications going to the Administrator, Director of Resident Care, Nurse Manager of Performance Quality & Development, and the Quality & Development Coordinator.
- A verbal or written response will be provided to the resident or representative within 10 business days of receipt of the complaint, where possible.
- If the complaint is unable to be resolved within 10 days, the home will provide in writing within 10 days an acknowledgement that the complaint has been received and a timeline when a response could be reasonably expected. Once resolved, a follow up written response is completed.

Review of the home's policy titled, 'Compliments, Recommendations or Concerns,' (Policy number: ADM D-05; Effective date: January 2015) procedures revealed:
- Residents or their representatives can bring forward compliments, recommendations or concerns by speaking directly to the RPN charge nurse on the unit, the RN in charge of the building, the department manager, the Director of Resident Care or the Administrator,
- Completing the "We Care What You Think" form and submitting to the Administrator
- All concerns received, shall be acknowledge as soon as possible by the staff receiving them, and are to be communicated to the manager of the department and acted upon immediately.
- All managers receiving a compliment, recommendation, or concern from a resident or representative shall record them on the Compliments, Recommendations and Concerns Log.

Review of the home's Compliments, Recommendations and Concerns Log revealed that there were no logs for the month of August. There was one log regarding the complainant's concerns in an identified month (no date or year was listed).

Interviews with the DOC revealed that the DOC and the administrator have responded to

the complainant's ongoing concerns.

The licensee was unable to provide records to demonstrate the: date each complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; and every date on which any response was provided to the complainant and a description of the response. [s. 101. (2)]

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**WN #10: 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 were secured and locked.

During an interview inspector observed PSW #111 pull out of his/her pocket a prescribed an identified medication and handed to a staff from an upcoming shift. The interview with the PSW revealed that he/she was to provide the identified medication to resident #032 before the end of his/her shift because the resident refused care earlier, and the PSW was not able to provide the identified medication earlier. Initially, the PSW revealed that the prescribed medication was given to him/her at an identified shift by the RPN #110 to provide to the resident. However, on the second interview the next day, the PSW confirmed that he/she took the prescribed medication from an identified area in the resident's room. The PSW also confirmed that the prescribed medication was kept in the resident's room, on an identified area for convenience to the staff. He/she indicated they needed to have an immediate access to the prescribed medication when the resident agree to receive care, as the resident may walk away if they wait for the RPN or PSW to go and take medication from the treatment room.

Interview with RPN #130 confirmed that they leave the prescribed medication in the resident's room for those residents who are non-compliant with care for the identified medication for convenience for the PSW to provide when the resident agree to receive the identified care.

Interview with RN #119 confirmed all prescribed medications should be kept in the nursing treatment cart and locked in the treatment room when they are not used. [s. 129. (1) (a)]

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**

**Issued on this 18th day of January, 2018**

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

**Original report signed by the inspector.**

Ontario

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

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

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

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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | IVY LAM (646), GORDANA KRSTEVSKA (600) |
| **Inspection No. / No de l'inspection :** | 2017_484646_0014 |
| **Log No. / No de registre :** | 024078-17 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Jan 4, 2018 |
| **Licensee / Titulaire de permis :** | CORPORATION OF THE COUNTY OF SIMCOE<br>1110 Highway 26, Midhurst, ON, L0L-1X0 |
| **LTC Home / Foyer de SLD :** | SUNSET MANOR HOME FOR SENIOR CITIZENS<br>49 RAGLAN STREET, COLLINGWOOD, ON, L9Y-4X1 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Jane Sinclair |

To CORPORATION OF THE COUNTY OF SIMCOE, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to include the following:

1) Ensure strategies are developed and implemented to ensure resident #021 and other residents receiving 1:1 monitoring, receive 1:1 monitoring at the specified times as directed by the plan of care.

2) Ensure a communication system is developed and implemented between 1:1 staff, PSWs and registered staff to ensure that resident #021 is monitored while the assigned 1:1 staff member is unavailable.

3) Ensure that frontline staff who provide care for resident #021 (PSWs, registered staff, activation staff, dietary staff) are aware of ongoing and updated strategies and interventions to minimize risk of altercations and potentially harmful interactions for residents with responsive behaviours who receive 1:1 monitoring.

The plan is to include the required tasks, the person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to ivy.lam@ontario.ca by January 18, 2018.

**Grounds / Motifs :**

1. 1. The home has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

This inspection had been initiated in response to a complaint (log #022771-17) related to alleged abuse by resident #021 toward multiple identified co-residents.

A review of resident #021's admission care plan indicated that the resident had been identified with responsive behaviours. The care plan indicated that the resident was triggered by noisy environments and should the resident exhibit responsive behaviours, the staff were directed to take the resident for walks to a quiet area and approach the resident from the front and remain at a safe distance.

A review of the clinical records identified that resident #021 had been assessed by the Behavioural Support System (BSS) Mobile Support Team on an identified start date. A review of BSS notes on an identified time period indicated that the resident had identified behaviours with identified triggers. The BSS recommended that the resident be provided an identified style of room accommodation, and suggested identified activities and approaches to interact with the resident.

Interview with the Program and Support Services (PSS) supervisor indicated that 1:1 staffing for resident #021 began on an identified date at an identified range of hours of monitoring, and that the hours of monitoring were increased at a later date to prevent risk of altercations between resident #021 and co-residents.

Review of resident #021's progress notes revealed several incidents of altercations between resident #021 and co-residents on a number of identified dates.

The PSS supervisor confirmed that, as per the home's records, on an identified date when resident #021 had an altercation with resident #023 at an identified home area, there was no 1:1 agency staff available and the home provided their own PSW for 1:1 monitoring for the resident. Interviews with PSWs #111, #122, and RPN #110 revealed that when the 1:1 staff are not there, the staff will

monitor resident #021. RPN #110 further revealed that it is difficult for the staff to monitor resident #021 when the 1:1 is not on the unit.

Review of resident #021's plan of care did not reveal interventions related to how staff were to monitor resident #021 when the 1:1 staff was on break, or when 1:1 agency staff were not available.

Interview with Registered Practical Nurse (RPN) #110 revealed that at the time of the altercation that occurred on a subsequent identified date, where resident #021 demonstrated responsive behaviours toward resident #008, the 1:1 agency staff was having his/her break. RPN #110 was not able to relay if the 1:1 staff had notified the registered staff that he/she was going on break at the time.

Interviews with PSW #122, 1:1 agency staff #139 and #138 revealed that an identified approach was used with resident #021. Further interviews with PSW #122, RPN #125, and the Director of Care (DOC) revealed that having the 1:1 available with resident #021 was an effective intervention in assisting residents. Interview with PSS supervisor and RPN #110 revealed that there were times when coverage for when the 1:1 agency staff was not available. Interviews with RPN #110, RN #136, and the DOC revealed that there were no directions developed and implemented at the times of the abovementioned incident for when the 1:1s would go on break, and no planned communication process between agency and home staff for when 1:1 agency staff specific for resident #021 was not on the unit, to ensure continued monitoring of resident #021.

Further, the registered staff, Professional Standards Supervisor and the DOC revealed that the interventions to minimize the risk of altercations and potentially harmful interactions between resident #021 and co-residents were not developed or implemented during the abovementioned incidents when the 1:1 staff specific for resident #021 was not available for the resident, or was not with the resident.

The severity of the non-compliance was potential for actual harm.

The scope of the non-compliance was isolated.

A review of the home's compliance history revealed ongoing non-compliance with a Voluntary Plan of  Correction (VPC) or Compliance Order (CO). (646)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Apr 06, 2018

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

**Issued on this  4th  day of January, 2018**

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

Ontario

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

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

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

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

**Name of Inspector /**
**Nom de l'inspecteur :** Ivy Lam

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