Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 28, 2016	2016_247508_0004	003774-16	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

GARDEN CITY MANOR
168 Scott Street St. Catharines ON L2N 1H2

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

ROSEANNE WESTERN (508), CATHY FEDIASH (214), GILLIAN TRACEY (130), KELLY HAYES (583)

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): February 10, 11, 12, 16, 17, 18, 19, 22, 23, 24, 25, 26, 29, March 2, 3, 4th.

The following inspections were conducted concurrently with this Resident Quality Inspection (RQI), Complaint inspections – log #(s) 016647-15, 029421-15, 003491-16, 000602-15, 006963-14, in relation to resident care, log # 002107-14 in relation to resident to resident abuse, log # 005496-15, in relation to residents' rights, Critical Incident(s) – log #(s) 009617-15, 010132-15, 012166-15, 032905-15, 036478-15, 000461-15, 005724-15, 034194-15, 035546-15, 006646-14, 006647-14, 005319-16, in relation to responsive behaviours, 014657-15, 029679-15, 035244-15, 001834-14, 007838-15, 006804-14, 006221-16, in relation to alleged staff to resident abuse, 013357-15 and 005790-16, in relation to missing benzodiazepines, 017547-15, 017746-15, 026841-15, 030624-15, 002427-15, 002922-15, 005124-15, 008980-15, in relation to falls prevention and management, 034134-15, in relation to weight loss, 001055-16 and 018643-15, in relation to an "other" incidents, 002567-15, in relation to disease outbreak. Follow up inspections – log #(s) 012104-15, in relation to staff training, 012134-15, in relation to resident plan of care, 012138-15, in relation to responsive behaviours, 006061-16, in relation to bed rail safety.

During the course of the inspection, the inspector(s) spoke with the Executive Director(ED); the Director of Care(DOC); the Assistant Directors of Care(ADOC); Environmental Service Manager(ESM); Food Service Manager(FSM); Activation Manager; Infection Control Nurse; Resident Assessment Instrument(RAI)Co-ordinator; Registered Dietitian (RD); housekeeping staff; Registered Nurses (RN); Registered Practical Nurses (RPN); Personal Support Workers(PSW), Residents Council Vice-President; Family Council President; residents and families. Inspectors also reviewed relevant clinical records; policies and procedures; training records; program evaluations; critical incidents submitted by the home; the home's complaint log and investigative notes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2015_189120_0099	508
O.Reg 79/10 s. 26. (3)	CO #003	2015_341583_0006	508
O.Reg 79/10 s. 53. (4)	CO #005	2015_341583_0006	508
LTCHA, 2007 S.O. 2007, c.8 s. 76. (7)	CO #001	2015_341583_0006	508

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's policy Resident Non-Abuse LP-C-20, revised December 2013, indicated: Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Executive Director (ED) or, if unavailable, to the most senior Supervisor on shift at that time. The person reporting the suspected abuse will follow the home's reporting requirements to ensure the information is provided to the Executive Director immediately.

In March, 2015, resident #906 was assisted to bed by staff following a fall. Staff #190 observed staff #214 apply a restraining device. The resident did not usually have this restraining device while in bed. The following day, the resident informed staff that they did not want this restraint applied. Staff #214 was disciplined as a result of the incident. The home confirmed that staff #214 violated the home's non-abuse policy. The incident was investigated once the resident informed staff of what had happened, but it was not reported to the Director until the next day. (Inspector #130). [s. 20. (1)]

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

The home's policy Resident Non-Abuse LP-C-20, revised December 2013, indicated: Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Executive Director (ED) or, if unavailable, to the most senior Supervisor on shift at that time. The person reporting the suspected abuse will follow the home's reporting requirements to ensure

the information is provided to the Executive Director immediately.

In December, 2015, resident #900 was found on top of resident #901, in resident #901's bed. Resident #901 appeared scared and requested staff assistance. Although there was no evidence that the resident had been abused, the DOC confirmed that the incident had a negative outcome to the resident. The home did not report the incident to the Director until the following day. This information was confirmed by the Critical Incident Submission (CIS) and the DOC. (Inspector #130).

PLEASE NOTE: This non-compliance was identified during a Critical Incident(CI) inspection conducted concurrently with this RQI. [s. 20. (1)]

3. The licensee failed to ensure that the policy that promotes zero tolerance of abuse and neglect of residents was complied with. The home's policy Resident Non-Abuse LP-C-20, revised December 2013, indicated: Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Executive Director (ED) or, if unavailable, to the most senior Supervisor on shift at that time. The person reporting the suspected abuse will follow the home's reporting requirements to ensure the information is provided to the Executive Director immediately.

In December, 2015, staff found resident #910 on top of cognitively impaired resident #911 touching the resident inappropriately. The DOC confirmed the incident was not reported immediately to the ED and not reported to the Director until three days after the incident. (Inspector #130)

PLEASE NOTE: This non-compliance was identified during a Critical Incident(CI) inspection conducted concurrently with this RQI. [s. 20. (1)]

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

In July, 2014, a registered staff member had reported to the nursing managers and the Executive Director (ED) during an unrelated meeting, that she had witnessed a staff member being rough with and speaking inappropriately towards resident #218.

According to the registered staff member, the incident had taken place approximately two to three weeks prior and the registered staff member did not report this to anyone at that

time.

The home's policy Resident Non-Abuse LP-C-20, revised December 2013, indicated: Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Executive Director (ED) or, if unavailable, to the most senior Supervisor on shift at that time.

The person reporting the suspected abuse will follow the home's reporting requirements to ensure the information is provided to the Executive Director immediately.

It was confirmed by the Director of Care during an interview on February 18, 2016, that the written policy that promoted zero tolerance of abuse and neglect of residents was not complied with.

PLEASE NOTE: This non-compliance was identified during a Critical Incident(CI) inspection conducted concurrently with this RQI. [s. 20. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

According to Critical Incident Submission (CIS) #2364-000109-15, resident #207 was witnessed by staff touching resident #208 inappropriately in December, 2015. Due to resident #208 being cognitively impaired, the resident was incapable of giving consent

and this incident was defined as non-consensual touching.

It was confirmed through clinical records and by the Associate Director of Care on February 17, 2016, that resident #207 was not protected from abuse by anyone.

PLEASE NOTE: This non-compliance was identified during a Critical Incident(CI) inspection conducted concurrently with this RQI. [s. 19. (1)]

2. The licensee failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

According to Critical Incident Submission (CIS) #2364-000044-15, resident #205 was identified as having cognitive impairment and exhibited responsive behaviours which included wandering into co-residents rooms. On an identified date in May, 2015, it was observed by staff that resident #205 wandered into resident #204's room. Resident #204 was then observed by staff going into their room while resident #205 was still in there. Staff responded and when staff entered the resident's room, both residents were partially undressed.

A review of the clinical record indicated that resident #205 was not injured or upset; however, the resident was not capable of giving consent to any touching.

It was confirmed by the Assistant Director of Care (ADOC) during an interview on February 11, 2016, that resident #205 was not protected from abuse by co-resident #204.

PLEASE NOTE: This non-compliance was identified during a Critical Incident(CI) inspection conducted concurrently with this RQI. [s. 19. (1)]

3. The licensee failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A review of the progress notes documented in April, 2015, identified resident #303 pushed resident #307 causing resident #307 to fall to the floor. Resident #307 was transferred to hospital for assessment the same day, and the home was notified the following day, that resident #307 sustained an injury.

In the Critical Incident(CI) report submitted by the home, it was identified that resident

#303 had known physical responsive behaviours and that resident #307 was not protected from abuse by anyone.

A review of the progress notes documented in May, 2015, identified resident #303 hit resident #306 which resulted in an injury. In an interview conducted by staff at the home after the incident, resident #306 shared they were fearful of resident #303. In the critical incident report submitted by the home, it was identified that the resident #303 was not protected from abuse by anyone.

A review of the progress notes documented in February, 2016, identified resident #303 hit resident #404 which resulted in an injury to resident #404. Resident #303 had known responsive behaviours and it was documented in December, 2015 and in January, 2016 that resident #303 demonstrated physical responsive behaviours towards resident #404. In the critical incident report submitted by the home, it was identified that resident #404 was not protected from abuse by anyone.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 005724-15, conducted concurrently during this Resident Quality Inspection. (#583) [s. 19. (1)]

4. The licensee failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

In March, 2015, resident #906 was assisted to bed by staff following a fall. Staff #190 observed staff #214 applied a restraining device. According to the plan of care the resident did not require the use of this restraining device.

The following day, the resident informed staff that they did not want this restraining device. Staff #214 confirmed that they knew applying the device was "not good" and that it restrained the resident.

The DOC confirmed that resident #906 was not protected from emotional abuse in March, 2015. (Inspector #130). [s. 19. (1)]

5. The licensee failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

In December, 2015, resident #900 was found on top of resident #901, in resident #901's

bed. Resident #901 appeared scared and requested staff assistance. The DOC confirmed that the incident had a negative outcome to the resident.

In December, 2015, resident #901 was not protected from sexual or emotional abuse. (Inspector #130).

PLEASE NOTE: This non-compliance was identified during a Critical Incident(CI) inspection conducted concurrently with this RQI. [s. 19. (1)]

6. The licensee failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

In December, 2015, staff found resident #910 on top of cognitively impaired resident #911, touching the resident inappropriately. Resident #911 was cognitively impaired and could not consent to the touching.

The DOC confirmed resident #911 was not protected from abuse. (Inspector #130).

PLEASE NOTE: This non-compliance was identified during a Critical Incident(CI) inspection conducted concurrently with this RQI. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out, the goals the care was intended to achieve.

A review of resident #400's progress notes indicated that in October, 2015, the resident initiated an argument with a co-resident and was verbally and physically responsive toward the co-resident. No injuries were noted and the resident was redirected. A review of the resident's written plan of care had identified goals the care was to achieve for the resident's verbally responsive behaviours; however, had not identified the goals the care was intended to achieve for the resident's physically responsive behaviour.

An interview with the Director of Care confirmed that the written plan of care had not set out the goals the care was intended to achieve for the resident's physically responsive behaviour. (Inspector #214) [s. 6. (1) (b)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A review of resident #400's clinical record indicated that in October, 2015, the resident initiated an argument with a co-resident and was verbally and physically responsive toward the co-resident. No injuries were noted. A review of the Minimum Data Set (MDS) quarterly assessment coding, indicated that the resident was coded as demonstrating verbal, socially inappropriate behaviours and resistance to care. A review of the Resident Assessment Protocol (RAP) for behavioural, indicated that this was a new RAP; however, this assessment had not included the resident's verbal and physical responsive behaviours that had been demonstrated.

An interview with the DOC confirmed that the staff had not collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and complemented each other. (Inspector #214) [s. 6. (4) (a)]

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

A) During an interview with resident #402 during the Resident Quality Inspection, the resident indicated that staff #117 was rough when they were providing the resident's specific care need. A review of the resident's written plan of care indicated under responsive behaviours that the resident required care by two staff. A review of the home's internal investigation notes indicated that staff #117 had provided care with two staff on this date; however; had provided care alone when they provided this specific care need.

An interview with the Director of Care confirmed that care set out in the plan of care was not provided to the resident as specified in their plan. (Inspector #214) [s. 6. (7)]

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

the resident as specified in the plan.

B) It was indicated that resident #404 required a specific need related to personal hygiene and that staff did not have time and were working short. A review of the resident's current written plan of care indicated that this specific need was to be provided to the resident on certain days.

A review of the Point of Care (POC) task for this specific need was completed and on an identified date in February, 2016, the response was documented as "no".

An interview with staff #210 indicated that they were short staffed and had not had the time to provide this specific need on the day it was required to be provided to the resident.

An interview with the Director of Care confirmed that the care set out in the plan of care was not provided to the resident as specified in their plan.

This non-compliance was identified as a result of Complaint Inspection #029421-15, which was conducted simultaneously with the RQI. (Inspector #214) [s. 6. (7)]

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

C) According to resident #905's plan of care dated August, 2015, staff were to monitor the resident to ensure falls interventions were in place for this resident.

The resident sustained a fall with injury in October, 2015. A progress note indicated a post fall assessment had been completed and confirmed that one of the interventions had not been in place as per the plan.

An assessment completed in October, 2015, indicated the resident had a specific intervention in place to prevent them from attempting self -transfers. The DOC authorized additional staffing; however the home was unable to fill the shifts when the resident sustained subsequent falls after this date. This information was confirmed by the DOC.

Care was not provided in accordance with the plan of care. (Inspector #130) [s. 6. (7)]

6. The licensee failed to ensure that the care set out in the plan of care was provided to

the resident as specified in the plan.

D) According to Critical Incident (CI) #2364-000037-15, in April, 2015, five residents who required various care needs throughout the shift were not provided the care as specified in their plans.

An interview with the DOC on February 18, 2016, confirmed that after the incident had been brought to her attention, an investigation was initiated and concluded that the identified residents did not receive the care that they required on this shift in April, 2015.

It was confirmed through documentation, the CI and during an interview with the Director of Care that the care set out in the plan of care was not provided to these residents as specified in their plan.

PLEASE NOTE: This non-compliance was identified during a Critical Incident(CI) inspection conducted concurrently with this RQI. [s. 6. (7)]

7. The licensee 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 changed or when care set out in the plan was no longer necessary.

A) The written plan of care for resident #905, documented in October, 2015, indicated staff were to "Check every 1 hour to ensure safety"; however, 18 days later a progress note indicated that safety checks had been increased to q. 15 minutes.

A progress note, indicated the Substitute Decision Maker (SDM) had informed the home that during the resident's recent hospital admission, a Doctor had advised the SDM that the resident was palliative.

A progress note documented approximately a month later, indicated the resident was assessed by their attending physician and "deemed palliative". The plan of care indicated, from that time period the resident had been bedfast and receiving comfort measures only.

The written plan of care was not updated to include this change in status. The resident passed away in the home on an identified date in 2015.

This information was confirmed by the DOC. (Inspector #130). [s. 6. (10) (b)]

8. The licensee 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 changed or care set out in the plan was no longer necessary.

B) Resident #207 was identified as having responsive behaviours due to cognitive impairment.

In December, 2015, resident #207 was witnessed by staff touching a co-resident inappropriately while sitting next to this resident. The co-resident was incapable of giving consent and the incident was defined as non-consensual touching.

A review of the resident's clinical record indicated that the home put strategies and interventions in place such as increased monitoring of resident #207 to minimize the risk of a re-occurrence; however, the resident's written plan of care had not been updated to include this responsive behaviour.

It was confirmed by the ADOC during an interview on February 23, 2016, that the resident's plan of care had not been reviewed and revised when the resident's care needs changed.

PLEASE NOTE: This non-compliance was identified during a Critical Incident(CI) inspection conducted concurrently with this RQI. [s. 6. (10) (b)]

9. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

C) Resident #900 was identified as having responsive behaviours which included wandering into co-resident's rooms. In December, 2015, resident #900 was observed laying on top of resident #901, in resident #901's bed. Staff observed resident #901 was upset and appeared scared.

A review of resident #900's clinical record indicated that strategies and interventions had been implemented to minimize a re-occurrence after this incident; however, the resident's responsive behaviour plan of care had not been revised.

This information was confirmed by the DOC. (Inspector #130).

PLEASE NOTE: This non-compliance was identified during a Critical Incident(CI) inspection conducted concurrently with this RQI. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

A) Resident #400 shared during an interview that they have not had a specific care need provided since admission. A review of the resident's clinical record indicated that documentation was completed and it was indicated that on two identified dates in February, 2016, the resident refused this specific care need. A review of the resident's progress notes indicated that no documentation was entered as to why the resident refused.

An interview with the Director of Care confirmed that it was the home's protocol that all refusals of care were to be reported to the registered staff and documented in the resident's progress notes and that this had not occurred when the resident refused this specific care need on the specified dates identified. [s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place was complied with.

B) The home's policy titled: Management of Narcotic and Controlled Drugs LTC-F-80, revised November 2015, indicated: The nurse would sign the pharmacy delivery form to verify that the package was received in the secure sealed container/bag. Two Nurses, together upon opening the narcotic and controlled drug(s) sealed container/bag, must verify and document drug and amount received on a Narcotic and Controlled Drug Count Form.

On June 9, 2015, the home submitted a Critical Incident Submission (CIS) reporting that a blister pack card of a controlled substance sent by pharmacy for a new admission, was unaccounted for.

The home's internal investigation concluded that it was likely that the missing card, which had been sent along with other medications, had not been in the bag sent from the pharmacy. The two nurses who received the bagged medication confirmed they co-signed the pharmacy delivery form to confirm receipt of the controlled substance, without confirming that it was actually received.

The ADOC confirmed the home's policy: Management of Narcotic and Controlled Drugs LTC-F-80 had not been complied with. (Inspector #130)

PLEASE NOTE: This non-compliance was identified during a Critical Incident(CI) inspection conducted concurrently with this RQI. [s. 8. (1) (b)]

3. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

C) The home's policy titled: Resident's Individual Narcotic and Controlled Drug Count Sheet, Policy Number: 4.3, revised November 2015, indicated: Each dose of every controlled substance was accounted for on an individual narcotic sheet/record and MAR (Medication Administration Record) sheet.

On an identified date in February, 2016, a progress note and the e-MAR (Electronic Medication Administration Record) confirmed that RPN #162, administered a dose of a controlled substance to resident #913. The administered dose was not recorded on the Resident's Individual Narcotic and Controlled Drug Count Sheet, as required by the home's policy.

This information was confirmed by the DOC. (Inspector #130)

PLEASE NOTE: This non-compliance was identified during a Critical Incident(CI) inspection conducted concurrently with this RQI. [s. 8. (1) (b)]

4. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

D) It was observed by the Inspector on two identified dates in February, 2016, that a personal item belonging to resident #216 had a strong odor that resembled urine. On an identified date in February, 2016, it was confirmed by further observations by the Inspector that the odor was coming from the resident's personal item and not from the resident.

A review of the 'Weekly Resident Equipment Cleaning Record', indicated that resident #210 was to have this personal item cleaned weekly.

On an identified date in February, 2016, the resident refused to have the personal item cleaned due to an altercation with PSW #024. Four days later, the resident was observed by the Inspector with the personal item .

An interview with the DOC indicated that the expectation was if the resident refused to have their personal items cleaned as scheduled, staff would make further attempts to clean it and not wait until the next scheduled date.

It was confirmed by the DOC during an interview on March 3, 2016, that staff did not comply with home's weekly cleaning system. [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 any plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

On an identified date in December, 2015, staff found resident #910 being inappropriate with resident #911. Resident #911 was cognitively impaired and could not consent to the inappropriate touching. The DOC confirmed the incident, including assessments and any other action taken with respect to the care of resident #910 after the incident, was not documented in the resident's clinical record. (Inspector #130)

PLEASE NOTE: This non-compliance was identified during a Critical Incident(CI) inspection conducted concurrently with this RQI. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident`s responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 36. Common law duty

Specifically failed to comply with the following:

s. 36. (2) If a resident is being restrained by a physical device pursuant to the common law duty described in subsection (1), the licensee shall ensure that the device is used in accordance with any requirements provided for in the regulations and that any other requirements provided for in the regulations are satisfied. 2007, c. 8, s. 36. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident being restrained by a physical device pursuant to the common law duty described in subsection (1), failed to ensure that the device was used in accordance with any requirements provided for in the regulations and that any other requirements provided for in the regulations were satisfied.

On an identified date in March, 2015, resident #906 was assisted to bed by staff following a fall. Staff #190 observed staff #214 apply a restraining device to the resident. According to the plan of care the resident did not require the use of this restraining device. Staff #214 confirmed that they knew that this device had a restraining effect.

The licensee failed to ensure that a resident being restrained by a physical device pursuant to the common law duty described in subsection (1), failed to ensure that the device was used in accordance with any requirements provided for in the regulations and that any other requirements provided for in the regulations were satisfied.

On an identified date in March, 2015, resident #906 was assisted to bed by staff following a fall. Staff #190 observed staff #214 apply a restraining device to the resident. According to the plan of care the resident did not require the use of this restraining device. The following day, the resident indicated that they did not want the restraining device and expressed that they were upset. Staff #214 confirmed in a written statement that applying the restraining device was not good and that it restrained the resident.

The DOC confirmed there was no physician's order obtained for the use of the restraint nor was the restraint consented to by the resident. (Inspector #130). [s. 36. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident is being restrained by a physical device, that the device is used in accordance with any requirements provided for in the regulations and that any other requirements provided for in the regulations are satisfied, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) Resident #201 sustained a fall resulting in an injury on an identified date in February, 2015. The DOC was interviewed and confirmed that a post fall assessment using a clinically appropriate assessment instrument that was specifically designed for falls, had not been completed after the fall. (Inspector #130).

PLEASE NOTE: This non-compliance was identified during a Critical Incident(CI) inspection conducted concurrently with this RQI. [s. 49. (2)]

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

B) Resident #217 had an unwitnessed fall on an identified date in January, 2015, and it was determined after a "head to toe" assessment that the resident did not sustain an injury. On an identified date in February, 2015, the resident complained of pain and was sent to hospital at for further assessment. The resident was hospitalized due to multiple health concerns, including an injury.

The resident returned to the home and on the following day after re-admission, the resident had another fall with no injury. A review of the resident's clinical record indicated that post-fall assessments using a clinically appropriate assessment instrument specifically designed for falls had not been conducted for either of these falls.

It was confirmed during an interview with the ADOC on February 17, 2016, that the resident had not been assessed using a clinically appropriate assessment instrument that was specifically designed for falls when the resident fell on two identified dates in 2015.

PLEASE NOTE: This non-compliance was identified during a Critical Incident (CI) inspection #002427-15, conducted concurrently during this Resident Quality Inspection. [s. 49. (2)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #206 had an unwitnessed fall on an identified date in 2015, and was transferred to hospital for further assessment due to decreased mobility and pain.

It was confirmed at the hospital that the resident sustained an injury; the resident was treated and sent back to the home later that day. The resident was assessed when the resident returned to the home and it was identified that the resident was having pain. Pain medication was administered.

The resident continued to complain of pain for the next several days and new orders were received for pain medication to manage the resident's pain.

A review of the resident's clinical record indicated that the resident had ongoing complaints of pain; however, the resident was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

It was confirmed during an interview with the ADOC on February 17, 2016, that when the resident's pain was not relieved by initial interventions, the resident was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

PLEASE NOTE: This non-compliance was identified during a Critical Incident(CI) inspection conducted concurrently with this RQI. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident`s pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Resident #400 shared during an interview that they had not received a bath or shower since admission. A review of the Point of Care (POC) documentation under the question, "Bath did not occur because Resident declined" that was completed over a twenty-five day period in early 2016, indicated that on two identified dates during this period the documentation indicated "Not Applicable".

An interview conducted with staff #50 confirmed that the resident had not received a bath or shower twice weekly during the specified dates identified as staff did not have enough time to complete them.
[s. 33. (1)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

A review of the resident's Minimum Data Set (MDS) coding, between October 2015, and January, 2016, indicated that the resident had responsive behaviours.

A review of the resident's written plan of care indicated that a responsive behaviour care plan had not been developed. The Assistant Director of Care (ADOC) confirmed during an interview on February 22, 2016, that the MDS coding was accurate and the resident did not have a responsive behaviour care plan.

It was confirmed by the ADOC on February 22, 2016, that strategies had not been developed and implemented to respond to the resident demonstrating responsive behaviours. [s. 53. (4) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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 failed to ensure that the planned menu items were offered and available at each meal and snack.

A review of resident #402's detailed diet order used by dietary staff during meal service identified resident #402 was to receive a specific food item at meals. During an observation of the lunch service on February 25, 2016, from 1200 hours to 1230 hours resident #402 was observed not to be offered this specific food item with lunch. In an interview with resident #402 at 1230 hours they shared they had recently not been receiving this and requested to have it with their lunch. In an interview with staff #058 it was confirmed that resident #402 was not offered all their planned menu items during lunch service. [s. 71. (4)]

Issued on this 29th day of April, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROSEANNE WESTERN (508), CATHY FEDIASH (214), GILLIAN TRACEY (130), KELLY HAYES (583)
Inspection No. / No de l'inspection :	2016_247508_0004
Log No. / Registre no:	003774-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 28, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	GARDEN CITY MANOR 168 Scott Street, St. Catharines, ON, L2N-1H2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	KIM WIDDICOMBE

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that the policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The home shall re-educate all staff in the following areas:

- the home's policy that promotes zero tolerance of abuse and neglect, including how to respond to incidents of suspected sexual abuse.
- the reporting requirements for alleged or suspected abuse as per the home's abuse policy and the requirements under s. 24(1) in the Long Term Care Homes Act.
- the Residents' Bill of Rights.

Grounds / Motifs :

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

According to Critical Incident (CI) #2364-000044-14, a registered staff member had reported to the nursing managers and the Executive Director (ED) during an unrelated meeting, that she had witnessed a staff member being rough with and speaking inappropriately towards resident #218.

According to the registered staff member, the incident had taken place approximately two to three weeks prior and the registered staff member did not report this to anyone at that time.

The home's policy Resident Non-Abuse LP-C-20, revised December 2013 indicated: Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Executive Director (ED) or, if unavailable, to the most senior Supervisor on shift at that time.

The person reporting the suspected abuse will follow the home's reporting requirements to ensure the information is provided to the Executive Director immediately.

It was confirmed by the Director of Care during an interview on February 18, 2016, that the written policy that promoted zero tolerance of abuse and neglect of residents was not complied with.

PLEASE NOTE: This non-compliance was identified during a Critical Incident (CI) inspection conducted concurrently with this RQI. (508)

2. The licensee failed to ensure the policy that promotes zero tolerance of abuse and neglect of residents was complied with. The home's policy Resident Non-Abuse LP-C-20, revised December 2013 indicated: Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Executive Director (ED) or, if unavailable, to the most senior Supervisor on shift at that time. The person reporting the suspected abuse will follow the home's reporting requirements to ensure the information is provided to the Executive Director immediately.

In December, 2015, resident #900 was found on top of resident #901, in resident #901's bed. Resident #901 appeared scared and requested staff assistance. Although there was no evidence that the resident had been abused, the DOC confirmed that the incident had a negative outcome to the resident. The home did not report the incident to the Director until the following day. This information was confirmed by the Critical Incident Submission (CIS) and the DOC. (Inspector #130).

PLEASE NOTE: This non-compliance was identified during a Critical Incident (CI) inspection conducted concurrently with this RQI. [s. 20. (1)]

(130)

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

The home's policy Resident Non-Abuse LP-C-20, revised December 2013 indicated: Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Executive Director (ED) or, if unavailable, to the most senior Supervisor on shift at that time. The person reporting the suspected abuse will follow the home's reporting requirements to ensure the information is provided to the Executive Director immediately.

In December, 2015, resident #900 was found on top of resident #901, in resident #901's bed. Resident #901 appeared scared and requested staff assistance. Although there was no evidence that the resident had been abused, the DOC confirmed that the incident had a negative outcome to the resident. The home did not report the incident to the Director until the following day. This information was confirmed by the Critical Incident Submission (CIS) and the DOC. (Inspector #130).

PLEASE NOTE: This non-compliance was identified during a Critical Incident (CI) inspection conducted concurrently with this RQI. [s. 20. (1)]

(130)

4. This area of non-compliance has not been issued in the last three years. The severity of the following were determined to be minimal harm or potential for actual harm. The scope of the following was determined to be widespread.

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

The home's policy Resident Non-Abuse LP-C-20, revised December 2013 indicated: Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Executive Director (ED) or, if unavailable, to the most senior Supervisor on shift at that time. The person reporting the suspected abuse will follow the home's reporting requirements to ensure the information is provided to the Executive Director immediately.

In March, 2015, resident #906 was assisted to bed by staff following a fall. Staff #190 observed staff #214 apply a restraining device. The resident did not usually have this restraining device while in bed. The following day, the resident informed staff that they did not want this restraint applied. Staff #214 was disciplined as a result of the incident. The home confirmed that staff #214 violated the home's non-abuse policy.

The incident was investigated once the resident informed staff of what had happened, but it was not reported to the Director until the next day. (Inspector #130). [s. 20. (1)]

(130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 01, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee shall:

- develop and implement a system or process to review all incidents of resident to resident abuse with staff to identify causative factors/triggers to the incidents, develop and revise new and current interventions after each incident with all residents involved.

- ensure that all direct care staff are involved in the above process and that all staff are educated on the above process.

- educate all staff on the definition of abuse including all types of abuse.

- educate all staff on the home's policy on minimizing of restraints in relation to bed rails and the process/policy on obtaining consent for such.

Grounds / Motifs :

1. The licensee failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

In December, 2015, staff found resident #910 on top of cognitively impaired resident #911, touching the resident inappropriately. Resident #911 was cognitively impaired and could not consent to the touching.

The DOC confirmed resident #911 was not protected from abuse. (Inspector

#130).

PLEASE NOTE: This non-compliance was identified during a Critical Incident (CI)inspection conducted concurrently with this RQI. [s. 19. (1)]

(130)

2. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

In December, 2015, resident #900 was found on top of resident #901, in resident #901's bed. Resident #901 appeared scared and requested staff assistance.
The DOC confirmed that the incident had a negative outcome to the resident. In December, 2015, resident #901 was not protected from sexual or emotional abuse. (Inspector #130).

PLEASE NOTE: This non-compliance was identified during a Critical Incident (CI)inspection conducted concurrently with this RQI. [s. 19. (1)]

(130)

3. The licensee failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

In March, 2015, resident #906 was assisted to bed by staff following a fall. Staff #190 observed staff #214 applied a restraining device. According to the plan of care the resident did not require the use of this restraining device.
The following day, the resident informed staff that they did not want this restraining device. Staff #214 confirmed that they knew applying the device was "not good" and that it restrained the resident.

The DOC confirmed that resident #906 was not protected from emotional abuse in March, 2015. (Inspector #130). [s. 19. (1)]

(130)

4. The licensee of the long-term care home failed to ensure residents were protected from abuse by anyone.

A review of the progress notes documented in April, 2015, identified resident #303 pushed resident #307 causing resident #307 to fall to the floor. Resident #307 was transferred to hospital for assessment the same day, and the home was notified the following day, that resident #307 sustained an injury.

In the Critical Incident(CI) report submitted by the home, it was identified that resident #303 had known physical responsive behaviours and that resident #307 was not protected from abuse by anyone.

A review of the progress notes documented in May, 2015, identified resident #303 hit resident #306 which resulted in an injury. In an interview conducted by staff at the home after the incident, resident #306 shared they were fearful of resident #303. In the critical incident report submitted by the home, it was identified that the resident #303 was not protected from abuse by anyone.

A review of the progress notes documented in February, 2016, identified resident #303 hit resident #404 which resulted in an injury to resident #404. Resident #303 had known responsive behaviours and it was documented in December, 2015 and in January, 2016 that resident #303 demonstrated physical responsive behaviours towards resident #404. In the critical incident report submitted by the home, it was identified that resident #404 was not protected from abuse by anyone.

PLEASE NOTE: This non compliance was identified during a Critical Incident Inspection, log# 005724-15, conducted concurrently during this Resident Quality Inspection. (#583) [s. 19. (1)]

(583)

5. This area of non-compliance has not been issued in the last three years. The severity of the following were determined to be actual harm/risk. The scope of the following was determined to be widespread.

The licensee has failed to ensure that residents were protected from abuse by

anyone and free from neglect by the licensee or staff in the home.

According to Critical Incident Submission (CIS) #2364-000044-15, resident #205 was identified as having cognitive impairment and exhibited responsive behaviours which included wandering into co-residents rooms.

On an identified date in May, 2015, it was observed by staff that resident #205 wandered into resident #204's room. Resident #205 was then observed by staff going into their room while resident #205 was still in there. Staff responded and when staff entered the resident's room, both residents were partially undressed.

A review of the clinical record indicated that resident #205 was not injured or upset; however, the resident was not capable of giving consent to any touching.

It was confirmed by the Assistant Director of Care (ADOC) during an interview on February 11, 2016, that resident #205 was not protected from abuse by co-resident #204.

PLEASE NOTE: This non-compliance was identified during a Critical Incident (CI)inspection conducted concurrently with this RQI. [s. 19. (1)]

(508)

6. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

According to Critical Incident Submission (CIS) #2364-000109-15, resident #207 was witnessed by staff touching resident #208's inappropriately in December, 2015. Due to resident #208 being cognitively impaired, the resident was incapable of giving consent and this incident was defined as non-consensual touching.

It was confirmed through clinical records and by the Associate Director of Care on February 17, 2016, that resident #207 was not protected from abuse by anyone.

PLEASE NOTE: This non-compliance was identified during a Critical Incident (CI)inspection conducted concurrently with this RQI. [s. 19. (1)]

(508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 01, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

The licensee shall:

- develop an auditing system to ensure that staff are providing care to residents as specified in their plans in relation to personal hygiene, bathing, toileting, oral care, brief checks and changes, turning and repositioning and falls prevention equipment.

- ensure that when staff are not working at a full staffing compliment, a plan is developed to ensure that if residents did not receive the care that was to be provided to them, interventions will be implemented to ensure the residents care needs are met as per their plan.

Grounds / Motifs :

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

According to Critical Incident (CI) #2364-000037-15, in April, 2015, five residents who required various care needs throughout the shift were not provided the care as specified in their plans.

An interview with the DOC on February 18, 2016, confirmed that after the incident had been brought to her attention, an investigation was initiated and concluded that the identified residents did not receive the care that they required on this shift in April, 2015.

It was confirmed through documentation, the CI and during an interview with the Director of Care that the care set out in the plan of care was not provided to these residents as specified in their plan.

PLEASE NOTE: This non-compliance was identified during a Critical Incident (CI) inspection conducted concurrently with this RQI. [s. 6. (7)]

(508)

2. The licensee failed to ensure that care was provided to the resident as specified in the plan of care.

According to resident #905's plan of care dated August, 2015, staff were to monitor the resident to ensure falls interventions were in place for this resident.

The resident sustained a fall with injury in October, 2015. A progress note indicated a post fall assessment had been completed and confirmed that one of the interventions had not been in place as per the plan.

An assessment completed in October, 2015, indicated the resident had a specific intervention in place to prevent them from attempting self -transfers. The DOC authorized additional staffing; however the home was unable to fill the shifts when the resident sustained subsequent falls after this date.

This information was confirmed by the DOC. Care was not provided in accordance with the plan of care. (Inspector #130) [s. 6. (7)]
(130)

3. Previously issued as a VPC in January, March and June, 2015. The severity of the following were determined to be minimal harm or potential for actual harm. The scope of the following was determined to be widespread.

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

It was indicated that resident #404 required a specific need related to personal hygiene and that staff did not have time and were working short. A review of the

resident's current written plan of care indicated that this specific need was to be provided to the resident on certain days.

A review of the Point of Care (POC) task for this specific need was completed and on an identified date in February, 2016, the response was documented as "no".

An interview with staff #210 indicated that they were short staffed and had not had the time to provide this specific need on the day it was required to be provided to the resident.

An interview with the Director of Care confirmed that the care set out in the plan of care was not provided to the resident as specified in their plan.

This non-compliance was identified as a result of Complaint Inspection #029421 -15, which was conducted simultaneously with the RQI. (Inspector #214)

(214)

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

During an interview with resident #402 during the Resident Quality Inspection, the resident indicated that staff #117 was rough when they were providing the resident's specific care need. A review of the resident's written plan of care indicated under responsive behaviours that the resident required care by two staff.

A review of the home's internal investigation notes indicated that staff #117 had provided care with two staff on this date; however; had provided care alone when they provided this specific care need.

An interview with the Director of Care confirmed that care set out in the plan of care was not provided to the resident as specified in their plan. (Inspector #214) [s. 6. (7)]

(214)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 01, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 28th day of April, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Roseanne Western

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