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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 23, 2017	2017_642606_0005	016055-16, 016293-16, 019299-16, 020611-16, 027048-16, 027587-16, 027885-16, 027894-16, 028023-16, 028203-16, 028889-16, 029133-16, 029732-16, 030162-16, 032087-16, 032485-16, 032556-16, 033012-16, 033094-16, 033118-16, 033621-16, 000650-17, 004768-17, 004925-17, 005104-17, 006449-17, 006690-17, 007318-17, 008107-17	Critical Incident System

Licensee/Titulaire de permis

VILLA COLOMBO HOMES FOR THE AGED, INC.
40 PLAYFAIR AVENUE TORONTO ON M6B 2P9

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

VILLA COLOMBO HOMES FOR THE AGED INC.
40 PLAYFAIR AVENUE TORONTO ON M6B 2P9

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

JANET GROUX (606), JULIEANN HING (649), NATALIE MOLIN (652)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 30, 31, April 3, 4, 5, 6, 7, 10, 11, 12, 13, 18, 19, 20, 21, 24, 25, 26, 27, 28, May 1, 2, 4, 5, 8, 9, 10, 2017.

The following Critical Incidents were inspected:
Allegation of Staff to Resident Abuse- log # 028889-16, 030162-16, 032485-16, 032556-16, 033118-16, 007318-17, and 008107-17.
Resident to Resident Abuse-log #016055-16, 019299-16, 029732-16, 028203-16, 033012-16, 033621-16, and 027587-16.
Injury of Cause Unknown-log # 016293-16, 004925-17, and 006449-17.
Unexpected Death- log #029133-16, and 032087-16.
Falls- log # 020611-16, 027885-16, 027894-16, 027048-16, 033094-16, 000650-17, 004768-17, 005104-17, and 006690-17.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Assistant Executive Director (A)ED, Director of Resident Services (DRS), Director of Nursing of Units First and Second Floor, Director of Nursing of Units Third Floor, Director of Nursing of Units Fourth Floor, Director of Nursing of Units Fifth Floor, Social Workers (SW), Doctors, Housekeeping and Laundry Manager, Physiotherapists (PT), Maintenance Worker (MW), Housekeeping, Dietary Aides (DA), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Substitute Decision Makers (SDMs), and Residents.

During the course of the inspection, the inspectors conducted observations of residents and home areas, medication administration, infection control prevention and practices, reviewed clinical health records, staffing schedules/assignments, minutes of relevant committee meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Under O. Reg. 79/10, s.5 for the purpose of the definition of neglect in subsection 5 of the Act, neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Record review of a Critical Incident (CI) report revealed an allegation that resident #028 was not provided an identified assistance during an identified activity of daily living.

Record review of resident #028's written plan of care revealed resident #028 required an identified level of assistance from staff for an identified activity of daily living due to identified factors.

Record review of the home's investigation outcome on an identified date revealed information relevant to the incident related to PSW #100.

Interview with Social Worker (SW) #131 indicated PSW #100 was observed on an identified date initiating an identified care service to resident #028's and did not complete the identified care. SW#131 also mentioned resident #028 required the identified care need on the identified date because the resident had an identified change in condition on that day.

Interview with Director of Nursing Unit #117 revealed PSW #100 did provide the identified care to resident #028 and the outcome of the home's investigation concluded PSW #100 neglected to provide the identified care to the resident.

Interview with the Director of Resident Services (DRS) revealed the outcome of the home's investigation concluded that PSW #100 neglected resident #028.

The inspector made several attempts to contact PSW #100 without success. [s. 19. (1)]

2. "Physical Abuse" means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Record review of a CI reported an identified resident to resident incident between residents #008 and #009 resulting in injury to an identified area of his/her body.

Record review of resident #008's progress notes indicated on an identified date and time, staff observed resident #008 with resident #009 and resident #008 with an identified

object on him/her and resident #009 in an identified state and with an identified injury to an identified area of his/her body.

Review of resident #008's progress notes on an identified date and time indicated there had been a number of incidents of an identified responsive behaviour between resident #008 and #009. Documentation in the progress notes on identified dates and times revealed an identified number of incidents of responsive behaviours between the two residents prior to the above mentioned incident.

Interview with PSW #152 indicated resident #008 has an identified responsive behavior and was monitored according to an identified schedule of his/her whereabouts and was redirected by staff.

Interview with PSW #157 indicated resident #009 has identified responsive behaviours.

Interview with Registered Nurse (RN) #160 revealed resident #008 has an identified responsive behaviour particularly during an identified time and had been observed to display an identified responsive behaviour toward resident #009. He/she revealed resident #008 was monitored frequently and was redirected by staff and stated the interventions were not always effective. Further interview with the RN indicated he/she responded to the above mentioned incident and confirmed resident #008 displayed an identified responsive behaviour toward resident #009 causing resident #009 to sustain an identified injury to an identified area of his/her body.

The licensee has failed to protect resident #009 from abuse by anyone. [s. 19. (1)]

3. Under O. Reg. 79/10, s.2 (1) for the purpose of the definition of "physical abuse" in subsection 2 of the Act, "physical abuse" means (c) the use of physical force by a resident that causes physical injury to another resident; mauvais traitement d'ordre physique

Record review of a CI reported to the MOHLTC that resident #048 sustained a fall on an identified date and time and was transferred to the hospital where he/she was diagnosed with an identified injury. The fall was unwitnessed by staff. Resident #050 told staff that resident #046 had displayed an identified responsive behavior toward resident #048.

A review of resident #048's progress notes on an identified date revealed the incident had been witnessed by resident #050 who was in the area and told the staff that he/she

saw resident #046 display an identified responsive behaviour towards resident #048.

Interviews with PSW #151 and #172 revealed resident #048's fall had been witnessed by resident #050 who was in the area at the time of the incident. They reported that resident #050 told them that resident #046 had displayed an identified responsive behaviour toward resident #048 resulting in a fall in an identified room. Registered Practical Nurse (RPN) #174 revealed resident #050 is able to say what he/she saw however, may not recall what happened after a few days.

Interview with RN #160 revealed RPN #174 informed him/her that resident #046 had displayed an identified responsive behaviour towards resident #048 resulting in a fall and transferred resident #048 to the hospital. RPN #174 told the inspector that he/she knew that resident #048 had displayed an identified responsive behaviour towards resident #046 and documented the same.

Interview with Director of Nursing #117 revealed that RPN #174 did not interpret the incident as abuse and therefore did not follow the home's abuse policy.

Interview with Director of Nursing #016 revealed that abuse had occurred but at the time of completing the CI did not identify this incident as abuse.

Interview with the DRS revealed that abuse had occurred and staff should have probed and gathered more information to determine what had occurred.

The scope of this non-compliance is patterned. Three out of three residents reviewed were identified in non-compliance.
The severity of the non-compliance and the severity of the harm and risk of further harm is actual harm/risk.
The home does have a history of ongoing non-compliance with a VPC or CO. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

Record review of a CI reported resident #044 had a fall and sustained an identified injury to an identified area of his/her body during care by a PSW.

A review or resident #044's written plan of care indicated that resident #044 required an identified number of staff to provide an identified care need related to identified factors.

Interview with PSW #128 revealed he/she had transferred the resident from his/her mobility aide to a chair in an identified area of the home. The PSW indicated he/she noticed resident #044 was not properly positioned in the chair but revealed he/she turned his back to to remove the mobility aide out of the way before proceeding to reposition the resident properly in the chair. The PSW revealed resident #044 stood up and fell forward and he/she indicated was unable to prevent the resident from falling.

The resident is no longer in the home for an interview.

Interview with Director of Nursing #143 revealed PSW #128 should have ensured that the resident was properly seated in the regular chair before he/she turned away.

Interview with the DRS revealed the PSW #128 should have seated the resident properly in the regular chair.

The scope of this non-compliance is isolated.
The severity of the non-compliance and the severity of the harm and risk of further harm is actual harm/risk.
The home does have a history of previous noncompliance unrelated. [s. 36.]

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 has failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

Record review of a CI reported resident #044 had a fall and sustained an identified injury to an identified area of his/her body during an identified care by PSW.

A review of resident #044's written plan of care did not indicate the identified care that resident #044 should have received.

Interviews with PSWs #128, #126, and RPN #127 revealed that it has been the practice to provide the identified care to resident #044. PSW #126 and RPN #127 revealed that the family of resident #044 had requested the identified care to be provided to resident #044.

Interview with Director of Nursing #143 and RPN #127 revealed that resident #044 written plan of care had not been updated to reflect the identified care.

Interview with the DRS revealed that the resident's plan of care should have been updated to reflect the identified care for resident #044.

2. The licensee has failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

A review of resident #022's written plan of care revealed there were no focus, goals or interventions to address the resident's complaint of an identified medical condition and identified treatment order.

Record review of resident #022's readmission from the hospital orders on an identified date revealed an an order for an identified treatment.

Record review of resident #022's progress notes on an identified date revealed he/she

complained he/she was in an identified condition and had discontinued an identified treatment during an identified meal service.The progress notes revealed RPN #180 preformed an identified nursing measure which provided an identified the level of the resident's medical condition. RPN #080 reapplied resident #022's identified treatment and made identified adjustments to manage the resident's identified change in condition.

Record review of an identified home policy revealed that a physician's order was required to administer different level of the identified treatment.

Interview with RPN #180 revealed he/she had administered an identified level of the identified treatment for a short period of time to stabilize the resident's identified condition and later reduced the treatment level to the identified previous level. RPN #180 also revealed he/she did not inform the in-charge nurse or the doctor that he/she had made changes to the resident's treatment. RPN #180 stated he she/did not document that he/she had reduced the identified treatment to an identified level.

Interview with Director of Nursing #143 and the DRS revealed resident #022 treatment intervention should have been in the written plan of care and RPN #180 should have informed the in charge nurse and notified the doctor. [s. 6. (1) (c)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so their assessments are integrated and were consistent with and complement each other.

Record review of a CI revealed resident #022 was found by staff in an identified hallway of the home in an identified position on the floor. A medical emergency code was called and during the assessment, staff were unable to obtain the resident's vital signs.

1. Record review of resident's #022’s progress notes on an identified date revealed resident #022's indicated an identified body chemistry level was at an identified level during three identified times.

Record review of resident #022's identified body chemistry levels indicated identified levels during an identified period of time.

Interview with RPN #180 revealed that he/she did not inform the charge nurse or call the doctor when he/she had reassessed resident #022's identified body chemistry level during an identified time.

Interview with RN #108 revealed he/she was not informed by RPN#180 that resident #022's identified body chemistry levels were high during an identified date and times.

Interview with Director of Nursing Unit #143 revealed the expectation was that RPN #180 should have informed the charge nurse and called the doctor to inform him/her of the increase in resident #022's identified body chemistry levels on an identified date.

Interview with the DRS revealed the expectation was that RPN #180 should have contacted the doctor when resident #022's identified body chemistry levels was was an identified level on an identified date.

2. Record review of resident #022's progress notes on an identified date revealed he/she complained he/she was in an identified condition and had discontinued an identified treatment during an identified time. The progress notes revealed RPN #180 performed an identified nursing measure which provided an identified level of the resident's medical condition. RPN #080 reapplied resident #022's identified treatment and made identified adjustments to manage the resident's identified change in condition. There was no documentation to support the length of time resident #022 was administered the identified treatment and whether registered staff readjusted the identified treatment back to the identified prescribed dosage.

Record review of resident #022's progress notes on an identified date revealed he/she complained he/she was in an identified condition and had discontinued an identified treatment during an identified meal service.The progress notes revealed RPN #180 performed an identified nursing measure which provided an identified the level of the resident's medical condition. RPN #080 reapplied resident #022's identified treatment and made identified adjustments to manage the resident's identified change in condition.

Interview with RPN #180 revealed he/she did adjust resident #022's identified treatment to an identified level on an identified date and did not inform the charge nurse or the doctor.

Interview with Director of Nursing #143 revealed the expectation was that RPN #180 should have informed the doctor to obtain an order to increase the resident's identified treatment to an identified level.

Interviews with the DRS revealed the expectation was that RPN #180 should have

informed the charge nurse who would have further assessed the resident and made recommendations to contact the doctor if the resident required and increase in the prescribed identified treatment.

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

Record review of a CI stated that resident #045 had an identified incident while PSW #141 provided care and sustained an identified injury to an area of his/her body.

A review of resident #045's written plan of care on an identified date indicated the resident required an identified level of assistance for an identified activity of daily living.

Interview with PSW #141 revealed that he/she discovered that resident #045 was in an identified state and required immediate care. PSW #141 revealed that he/she performed an identified care routine with the resident in the identified area and indicated while he/she performed the identified task, the resident fell.

Interview with RN #108, Director of Nursing #143 and the DRS revealed PSW #141 did not follow the resident's plan of care and provided care as indicated in the resident's plan of care. [s. 6. (7)]

5. Record review of a CI reported resident #001 to have pain to an identified area of his/her body and was transferred to the hospital and was diagnosed with an identified medical condition.

Record review of resident's #001's plan of care indicated resident was diagnosed with an identified medical condition and required the staff to monitor and assess; and for the registered staff to report to the doctor signs and symptoms unrelieved by identified treatments and medications ordered by the doctor.

Record review of resident #001's progress notes revealed identified dates and time resident #001 was observed by staff and had verbalized pain to an identified area of his/her body. Further review of the progress notes indicated staff assessed and provided the resident with an identified nursing and medical interventions and it was documented the interventions were not effective.

Interview with PSW #112 revealed he/she worked on an identified date and time and

provided care to resident #001. The PSW stated he/she observed resident #001 to have pain to an identified part of his/her body and had verbalized the word pain in his/her language whenever the identified area of his/her body was when he/she touched or moved and that the PSW reported the resident's condition to RPN #109.

Interview with RPN #109 stated he/she was informed by PSW #112 during the identified time that resident #001 had complained of pain when he/she was being moved or touched and he/she monitored the resident during the shift and stated he/she did not initiate any other interventions.

Interview with PSW #113 stated he/she worked on an identified date and time and observed resident #001 to have pain when he/she had provided care and that the resident verbalized to the PSW that he/she had pain when an identified area of his/her body was touched and/or moved.The PSW stated he/she informed RPN #104 of his/her observation at an identified time that day.

RPN #104 stated he/she was informed by the night PSWs that resident #001 declined care on the identified date and time and indicated the resident would at times decline care when he/she is assigned a staff member who doesn't regularly provide care to the resident and he/she stated the PSW who was assigned to resident #001 that shift was a new staff member. RPN #104 stated resident #001 will sometimes exhibit this behaviour. He/she revealed that RPN #109 and him/her went to resident #00's room and assisted the resident to his/her mobility aide and was unaware that the resident had pain until much later on during the shift. The RPN indicated that when he/she became aware that resident #001 was having pain he/she initiated an assessment in the progress notes and the medical directive to administer an identified medication and an identified nursing intervention to the identified area of the resident's body and was monitored.

Interview with Director of Nursing #117 revealed the home's expectation was to make the resident comfortable and for the resident not to have pain and indicated the registered staff did not call the doctor until an identified date.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan. [s. 6. (7)]

6. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so their assessments are integrated and were consistent with and complement each other.

Record review of a CI reported resident #048 had a fall during an identified time and was transferred to the hospital and diagnosed with an identified medical diagnosis. The fall was unwitnessed by staff. Resident #050 told staff that resident #046 displayed an identified responsive behaviour towards resident #048.

The CI report indicated that the home initiated an identified monitoring record for resident #046.

The inspector requested a copy of the identified monitoring record that had been started on resident #046 after the incident but the home was unable to provide the documentation.

Interview with Director of Nursing #116 revealed that he/she had communicated with RPN #203 and RN #204 to initiate the identified monitoring record for resident #046 after his/her fall. He/she further revealed that he/she did not believe that the identified monitoring record had been started as he/was not able to locate the record.

Interview with PSW #151 revealed that he/she do not recall completing any documentation on an identified monitoring record for resident #046 after the above mentioned incident.

Interviews with RPNs #174 and #203 revealed that they do not recall completing an identified monitoring record for resident #046 after the above mentioned incident.

Interview with RN #204 revealed that he/she recall initiating the identified monitoring record for resident #046 but was unable to locate the record.

Interview with Director of Nursing #017 revealed that he/she was unable to locate the identified monitoring record that had been started on resident #046 and was unsure if one had been started for the resident.

Interview with the DRS revealed the identified monitoring record could have been initiated but not followed through. [s. 6. (7)]

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

Record review of a CI reported resident #047 had a fall from his/her mobility aide because an identified device had not been applied. The resident was transferred to the hospital for an assessment and was diagnosed with an identified medical diagnosis to identified areas of his/her body.

A review of resident #047's written plan of care on an identified date revealed the resident should use an identified device when he/she is in his/her mobility aide for safety related to falls.

The resident is no longer in the home for an interview.

Interview with PSW #167 revealed that he/she had worked with the resident during an identified date and time and the resident had been transferred to his/her mobility aide by the night staff. The PSW stated that he/she had taken the resident to an identified area of the home and provided an identified activity of daily living and had repositioned the resident in his/her mobility aide but did not check the identified device during these times.

PSW #167 told the inspector that he/she assisted resident #047 with care during an identified time and during this time left the resident to assist another resident from the identified area. The PSW indicated that while he/she assisted the other resident, resident #047 had been moved from an identified area. PSW #167 indicated as he/she was returning to the identified area of the home he/she observed the resident #047 in an identified position in his/her mobility aide and was not able to stop the resident from falling. This was when the PSW realized that the identified device had not been applied.

Interview with PSW #167 revealed that he/she had not checked to ensure that resident #047 had on the identified device at any time before the fall and thought the identified device had been applied by the night staff who had assisted the resident in his/her mobility aide earlier that day.

Interview with PSW #193 revealed that he/she had assisted the resident up in the mobility aide and had applied the identified device signed an identified home's monitoring record and left the resident at an identified area of the home at an identified date and time.

Interview with Director of Nursing #116 revealed that PSW #167 should have checked to ensure that the identified device was applied and removed every two hrs.

Interview with the DRS revealed that the staff should have followed resident# 047's plan of care and applied the identified device. [s. 6. (7)]

8. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Record review of a CI reported resident #047 had a fall from his/her mobility aide because an identified device had not been applied. The resident was transferred to the hospital for an assessment and was diagnosed with an identified medical diagnosis to identified areas of his/her body.

Resident #047 was not in the home during the inspection.

Record review of an identified monitoring record for resident #047 on identified dates revealed incomplete documentation. Further review of the identified monitoring record for identified months in 2016 indicated it had not been signed by the PSW on five identified dates in 2016.

Interview with PSW #164 revealed that he/she had provided an identified care to the resident on an identified date and time but had forgotten to document on the identified monitoring record.

Interview with PSW #197 revealed that he/she had provided an identified care on an identified date and time in 2016 but had forgotten to document on the identified monitoring record.

Interview with PSW #167 revealed that he/she had provide an identified care to the resident after an identified date and time and had forgotten to sign the identified monitoring record during the identified times. PSW #167 revealed that on two identified dates in 2016 an identified care equipment was not functioning and he/she did not sign the identified monitoring record as it could be done at anytime.

A review of the identified monitoring record on an identified date indicated it had been signed only during an identified time. PSW #167 revealed that he/she had signed the identified monitoring record on an identified date indicating he/she had completed the identified specific tasks required for the identified device even though he/she had not applied the identified device on resident #047.

Interview with RPN #127 revealed that the identified monitoring record should have been signed after the identified device was removed and reapplied.

Interview with Director of Nursing #116 revealed that PSW #167 has to ensure that the resident is checked at identified times according to the home's policy and procedure and sign the identified monitoring record.

Interview with DRS revealed that the PSW staff should have documented as they are checking the resident and not at the end of the shift. [s. 6. (9)]

9. Record review of a CI reported that resident #047 fell and was transferred to the hospital with an identified injury to identified areas of his/her body.

Resident #047 was not in the home during the course of the inspection.

Record review of an identified home's evaluation documented by the registered staff on an identified home's record during identified months in 2016, indicated incomplete documentation. Further review of three identified months in 2016 MAR documentation indicated that it has not been signed by the registered staff on identified dates and time in 2016.

Interview with RPN #162 revealed that he/she had evaluated the effectiveness of the identified device but had forgotten to document on the identified record on two identified dates in 2016.

Interview with RPN #163 revealed that he/she had evaluated the effectiveness of the identified device had signed the identified record on identified dates in 2016 but due to an issue with an identified equipment, the identified record showed up as not being signed.

Interview with RN #108 revealed that he/she had evaluated the identified device identified dates in 2016 and was unsure if he/she had signed the identified record on all the days. He/she indicated due to an identified issue with an identified home's system, it will sometimes show that it has not been signed when it had been signed.

Interview with Director of Nursing #116 revealed that the registered staff should be signing the identified record and ensuring the identified device was checked.

Interview with the DRS revealed that the registered staff should have checked and signed the identified monitoring record in the identified record. [s. 6. (9) 1.]

10. 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 care set out in the plan had not been effective.

Record review of a CI reported that resident #041 was found in an identified position at an identified date and time and had verbalized pain to an identified area of his/her body. The resident was transferred to the hospital for an assessment and was diagnosed with an identified injury to areas of his/her body.

Resident was not available for an interview.

Record review of resident #041's progress notes indicated resident #041 has an identified number of falls during an identified periods of time in 2016.

Record review of the resident's written plan of care dated during identified dates revealed that no new interventions were implemented when the resident continued to have falls during the identified time in 2016. The Director of Nursing #016 and #017 revealed that no assessment or reassessment had been completed during this period when resident continued to have falls. The Directors further revealed that resident #041's plan of care had not been updated or revised.

Interview with PT #007 revealed that resident #041 was not in any physiotherapy programs and he/she had not assessed resident after he/she started to have frequent falls during the identified times in 2016. The PT and RN #108 revealed that there had been monthly falls multidisciplinary meetings that are documented in PCC and revealed resident #041 had not been discussed at any of these meetings related to his/her falls.

Interview with the DRS revealed that no new interventions were documented or care plan revised after the resident started to have frequent falls during the identified times. [s. 6. (10)]

11. The licensee has failed to ensure that when a resident is reassessed and the plan of care reviewed and revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches were considered in the revision of the plan of care.

Record review of a CI reported an identified resident to resident incident.

Record review of resident #008's progress notes on an identified date and time that staff observed resident #008 and resident #009's in an identified area of the home with resident #008 with an identified object and resident #009 in an identified state and with an identified injury to an identified area of his/her body.

Record review of resident #008's plan of care on an identified date indicated the resident has identified a number of responsive behaviours related to the resident's medical condition and diagnoses and directed staff to monitor the resident's whereabouts and redirect him/her.

Record review of resident #009's plan of care on an identified date, indicated the resident had an identified responsive behaviour and directed staff to monitor and to follow an identified intervention.

Record review of resident #008's progress notes on an identified date and time that staff observed resident #008 and resident #009's in an identified area of the home with resident #008 with an identified object and resident #009 in an identified state and with an identified injury to an identified area of his/her body.

Interviews with PSW #157 and RPN #101 stated resident #009 has several identified responsive behaviours. They indicated that the resident's plan of care directed staff to monitor the resident for an identified time for his/her whereabouts and provide redirection.

Interview with RPN #160 indicated resident #009 has an identified responsive behaviour and has had incidents with resident #009 prior to the incident on an identified date. The RPN indicated resident #009 is monitored at an identified times by staff and redirected as required. He/she further indicated the interventions has not always been effective and no new interventions has been added to the resident's plan of care after the above mentioned incident.

Interviews with the DRS, and Director of Nursing #117, #143, and #120 indicated the home's responsive behaviour programs identified residents who have responsive behaviours and are assessed and referred for further support to manage their responsive behaviours when the plan of care is not effective.

The home has failed to ensure that when a resident is reassessed and the plan of care reviewed and revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches were considered in the revision of the plan of care.

The scope of this non-compliance is isolated.
The severity of the non-compliance and the severity of the harm and risk of further harm is actual harm/risk.
The home does have a history of previous noncompliance unrelated. [s. 6. (11) (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. 26. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

Record review of a CI reported to the MOHLTC that resident #048 sustained a fall on an identified date and time and was transferred to the hospital where he/she was diagnosed with an identified injury. The fall was unwitnessed by staff. Resident #050 told staff that resident #046 had displayed an identified responsive behavior toward resident #048.

On an identified date the inspector observed resident #046 sitting with co-residents waiting for a program to start. There were no concerns noted.

Interviews with PSWs #151, #172 #173, #113 revealed that an identified sound is a behavioural trigger for resident #046. PSW #151 and #113 revealed that they would put resident #046 to sit beside residents #051 and/or #052 in the lounge area as they will socialize with each other and participate in an identified activity.

Record review of resident #046's written plan of care on an identified date did not indicate a behavioural trigger to the identified sound and that staff were directed to place him/her to sit beside residents #051 and/or #052.

Interview with RPNs #174 and #203 revealed that an identified sound is a behavioural trigger for resident #046.

Interview with Director of Nursing #117 revealed that an identified sound is a trigger for resident #046 and would put him/her with other residents who are calm.

Interview with the DRS revealed that these behaviours and interventions should have be identified. [s. 26. (3) 5.]

Additional Required Actions:

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

Record review of a CI reported resident #001 to have a pain to an identified area of his/her body and was transferred to the hospital and was diagnosed with an identified medical condition.

Record review of an identified home's policy indicated the progress notes must be completed for acute episodes of acute pain and new complaint of pain.

Record review of resident #001's progress notes documented by RPN #104 indicated the resident verbalized that he/she had pain during an identified date and time to an identified area of his/her body. Further record review indicated there was no documentation during an identified date and time that resident #001 had verbalized that he/she was in pain.

Interview with PSW #112 indicated resident #001 had verbalized that he/she was in pain during an identified time and the PSW stated he/she informed RPN #109 of the resident's identified state during the shift.

Interview with RPN #109 stated he/she was informed by PSW #112 that the resident had verbalized pain to an identified area of his/her body and conducted an identified assessment and continued to monitor the resident. RPN #109 stated he/she did not document his/her assessment.

Interview with Director of Nursing #017 indicated it is the expectation of the home and good nursing practice that registered staff document their assessments and follow up in the progress notes. [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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Record review of a CI revealed resident #030 had a fall in an identified area of the home while he/she was being provided care by a PSW. The resident complained of pain to an identified area of his/her body and was diagnosed with an identified medical condition.

Record review of resident #030's assessment records on an identified date revealed when he/she fell an identified assessment had not been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Interview with PSW #175 revealed that he/she had stepped away to retrieve an identified resident's personal item in the same room when the resident fell.

Interview with RPN #124 revealed an identified assessment had not been completed for resident #030 when he/she fell on an identified date.

Interview with Director of Nursing #116 revealed that an identified assessment should been completed for resident #030 when he/she fell on an identified date.

Interview with the DRS stated the expectation is that an identified assessment should have been completed for resident #030 using the same assessment tool when the resident fell on an identified date.

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 the resident has fallen, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drugs supply,
including the following: All areas where drugs are stored shall be kept locked at all times, when not in use.

On an identified date and time the inspector observed an unlocked medication cart on an identified area of the home where residents and families were nearby.

The inspector waited for an identified time frame to observe if any of the two registered staff who were on the unit would notice the unlocked medication cart.

In identified areas of the medication cart, the inspector observed several identified monitoring tools, and topical creams including medications in their strip packaging including pre-poured pills in medication cups belonging to some residents. In another drawer, liquid medications were noted in bottles, and the narcotic folder and the narcotic drawer was observed to be locked.

At an identified time the inspector approached RPN #153 and RN #108 and inquired if the medication cart belonged to any of them. They informed the inspector that the medication cart was assigned to another registered staff who had gone on his/her break. It was observed by the inspector that one of the nurses immediately locked the medication cart.

Interview with RPN #137 at an identified time revealed that he/she had gone on break at an identified time. The RPN indicated he/she became distracted and had forgotten to lock the medication cart before going on break.

Interview with Director of Nursing #116 revealed that if the registered staff was not in front of the medication cart it should be locked as it was a safety hazard.

Interview with the DRS revealed the medication cart should be locked when not in use even if staff walked away including the e-MAR screen. [s. 130. 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 steps are taken to ensure the security of the drugs supply, including the following: All areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Record review of a CI reported to the MOHLTC that resident #048 had a fall and was transferred to the hospital where he/she was diagnosed with an identified medical condition. The fall was unwitnessed by staff. Resident #050 told staff that resident #046 had displayed an identified responsive behavior toward resident #048.

Under O. Reg. 79/10, s.2 (1) for the purpose of the definition of "physical abuse" in subsection 2 of the Act, "physical abuse" means (c) the use of physical force by a resident that causes physical injury to another resident; (“mauvais traitement d’ordre physique”).

A review of resident #048's progress notes documented by RPN #174 on an identified date revealed that the incident had been witnessed by resident #050 who was in bed at the time of the incident and told staff that he/she saw resident #046 display an identified responsive behaviour towards resident #048.

A review of an identified home's policy directed staff to immediately report any suspected or witnessed abuse to the MOHLTC Director through the Critical Incident Reporting System or after hour pager.

Interview with Director of Nursing #117 revealed RPN #174 did not interpret the incident as abuse and did not follow the home's abuse policy on reporting.

Interview with the DRS revealed RPN #174 did not identify this incident as abuse and therefore the home's abuse policy was not followed. [s. 20. (1)]

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. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(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).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that includes every date on which any response was provided to the complainant and a description of the response.

Record review of a CI reported resident #002 was transferred to the hospital for complaint pain to an identified area of his/her body of and was diagnosed with a medical diagnosis and injury of unknown cause.

Record review of resident #002's progress notes indicated resident verbalized pain to an identified area of his/her body during an identified time and date. He/she was assessed by RPN #102 to be pain. Resident was transferred to the hospital and was diagnosed with an identified medical diagnosis and injury to an area of his/her body of unknown cause.

Interview with the SDM of resident #002 stated he/she requested for the home to complete an investigation of how the resident sustained the injury. The SDM stated the home did not contact him/her of the conclusion of their investigation until he/she asked the home after an identified time.

Interview with Director of Nursing #120 stated he/she provided resident #002's SDM the outcome of the investigation but was unsure of the date the SDM was contacted. He/she stated it is the home's practice to keep records of the response to the SDM but he/she did not document their conversation. [s. 101. (2) (e)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. The licensee failed to ensure that the records of the residents of the home are kept at the home.

Record review of a CI reported an identified resident to resident incident between resident #008 and #009.

Interviews with PSW #152, RPN #101 and RN #160 indicated resident #008 had identified responsive behaviours and directed staff to initiate a specific intervention and that this was documented on a written monitoring record.

Review of resident #008's written monitoring records were not available for review.

Interview with Director Nursing Unit #117 stated the home was unable to locate the above mentioned the monitoring record for resident #008.

The licensee failed to ensure that the records of the residents of the home are kept at the home. [s. 232.]

Issued on this 7th day of July, 2017

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) :	JANET GROUX (606), JULIEANN HING (649), NATALIE MOLIN (652)
Inspection No. / No de l'inspection :	2017_642606_0005
Log No. / Registre no:	016055-16, 016293-16, 019299-16, 020611-16, 027048-16, 027587-16, 027885-16, 027894-16, 028023-16, 028203-16, 028889-16, 029133-16, 029732-16, 030162-16, 032087-16, 032485-16, 032556-16, 033012-16, 033094-16, 033118-16, 033621-16, 000650-17, 004768-17, 004925-17, 005104-17, 006449-17, 006690-17, 007318-17, 008107-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 23, 2017
Licensee / Titulaire de permis :	VILLA COLOMBO HOMES FOR THE AGED, INC. 40 PLAYFAIR AVENUE, TORONTO, ON, M6B-2P9
LTC Home / Foyer de SLD :	VILLA COLOMBO HOMES FOR THE AGED INC. 40 PLAYFAIR AVENUE, TORONTO, ON, M6B-2P9

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 Administrator / Nom de l'administratrice ou de l'administrateur : Tracey Comeau

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To VILLA COLOMBO HOMES FOR THE AGED, INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Upon receipt of this order the licensee shall,

1. Develop and submit a plan that includes the following requirements and the person responsible for completing the tasks:
2. Provide re-education and training to all staff in the home on the home's policy to promote zero tolerance of abuse and neglect of residents.
3. Ensure all staff are educated on how to identify and report resident to resident abuse.
4. The policy review and training shall include all definitions of abuse, and not be limited to resident to resident abuse, as identified within the home's abuse policy and within the Long-Term Care Homes Act, 2007, Ontario Regulations 79/10.

The plan to be submitted to janet.groux@ontario.ca on July 17, 2017.

Grounds / Motifs :

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

Under O. Reg. 79/10, s.2 (1) for the purpose of the definition of "physical abuse" in subsection 2 of the Act, "physical abuse" means (c) the use of physical force by a resident that causes physical injury to another resident; mauvais traitement d'ordre physique

Record review of a CI reported to the MOHLTC that resident #048 sustained a fall on an identified date and time and was transferred to the hospital where he/she was diagnosed with an identified injury. The fall was unwitnessed by staff. Resident #050 told staff that resident #046 had displayed an identified

responsive behavior toward resident #048.

A review of resident #048's progress notes on an identified date revealed the incident had been witnessed by resident #050 who was in the area and told the staff that he/she saw resident #046 display an identified responsive behaviour towards resident #048.

Interviews with PSW #151 and #172 revealed resident #048's fall had been witnessed by resident #050 who was in the area at the time of the incident. They reported that resident #050 told them that resident #046 had displayed an identified responsive behaviour toward resident #048 resulting in a fall in an identified room. Registered Practical Nurse (RPN) #174 revealed resident #050 is able to say what he/she saw however, may not recall what happened after a few days.

Interview with RN #160 revealed RPN #174 informed him/her that resident #046 had displayed an identified responsive behaviour towards resident #048 resulting in a fall and transferred resident #048 to the hospital. RPN #174 told the inspector that he/she knew that resident #048 had displayed an identified responsive behaviour towards resident #046 and documented the same.

Interview with Director of Nursing #117 revealed that RPN #174 did not interpret the incident as abuse and therefore did not follow the home's abuse policy.

Interview with Director of Nursing #016 revealed that abuse had occurred but at the time of completing the CI did not identify this incident as abuse.

Interview with the DRS revealed that abuse had occurred and staff should have probed and gathered more information to determine what had occurred.

The scope of this non-compliance is patterned. Three out of three residents reviewed were identified in non-compliance.
The severity of the non-compliance and the severity of the harm and risk of further harm is actual harm/risk.
The home does have a history of ongoing non-compliance with a VPC or CO. [s. 19. (1)]

(649)

2. "Physical Abuse" means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Record review of a CI reported an identified resident to resident incident between residents #008 and #009 resulting in injury to an identified area of his/her body.

Record review of resident #008's progress notes indicated on an identified date and time, staff observed resident #008 with resident #009 and resident #008 with an identified object on him/her and resident #009 in an identified state and with an identified injury to an identified area of his/her body.

Review of resident #008's progress notes on an identified date and time indicated there had been a number of incidents of an identified responsive behaviour between resident #008 and #009. Documentation in the progress notes on identified dates and times several incidents of responsive behaviours between the two residents prior to the above mentioned incident.

Interview with PSW #152 indicated resident #008 has an identified responsive behavior and was monitored according to an identified schedule of his/her whereabouts and was redirected by staff.

Interview with PSW #157 indicated resident #009 has identified responsive behaviours.

Interview with Registered Nurse (RN) #160 revealed resident #008 has an identified responsive behaviour particularly during an identified time and had been observed to display the identified responsive behaviour toward resident #009. He/she revealed resident #008 is monitored frequently and was redirected by staff and stated the interventions were not always effective. Further interview with the RN indicated he/she responded to the above mentioned incident and confirmed resident #008 displayed an identified responsive behaviour toward resident #009 causing resident #009 to sustain an identified injury to an identified area of his/her body.

The licensee has failed to protect resident #009 from abuse by anyone. [s. 19. (1)]

(606)

3. Under O. Reg. 79/10, s.5 for the purpose of the definition of neglect in subsection 5 of the Act, neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Record review of a Critical Incident (CI) report revealed an allegation that resident #028 was not provided an identified assistance during an identified activity of daily living.

Record review of resident #028's written plan of care revealed resident #028 required an identified level of assistance from staff for an identified activity of daily living due to identified factors.

Record review of the home's investigation outcome on an identified date revealed information relevant to the incident related to PSW #100.

Interview with Social Worker (SW) #131 indicated PSW #100 was observed on an identified date initiating an identified care service to resident #028's and did not complete the identified care. SW#131 also mentioned resident #028

required the identified care need on the identified date because the resident had an identified change in condition on that day.

Interview with Director of Nursing Unit #117 revealed PSW #100 did provide the identified care to resident #028 and the outcome of the home's investigation concluded PSW #100 neglected to provide the identified care to the resident.

Interview with the Director of Resident Services (DRS) revealed the outcome of the home's investigation concluded that PSW #100 neglected resident #028.

The inspector made several attempts to contact PSW #100 without success. [s. 19. (1)]

(652)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 25, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all staff in the home receive hands on training to demonstrate that staff use safe transferring and positioning techniques when assisting residents. The plans shall also include a system to audit and evaluate the training program.

The plan is to be submitted to janet.groux@ontario.ca by July 17, 2017.

Grounds / Motifs :

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

Record review of a CI reported resident #044 had a fall and sustained an identified injury to an identified area of his/her body during care by a PSW.

A review or resident #044's written plan of care indicated that resident #044 required an identified number of staff to provide an identified care need related to identified factors.

Interview with PSW #128 revealed he/she had transferred the resident from his/her mobility aide to a chair in an identified area of the home. The PSW indicated he/she noticed resident #044 was not properly positioned in the chair but revealed he/she turned his back to to remove the mobility aide out of the way before proceeding to reposition the resident properly in the chair. The PSW revealed resident #044 stood up and fell forward and he/she indicated was unable to prevent the resident from falling.

The resident is no longer in the home for an interview.

Interview with Director of Nursing #143 revealed PSW #128 should have ensured that the resident was properly seated in the regular chair before he/she turned away.

Interview with the DRS revealed the PSW #128 should have seated the resident properly in the regular chair.

The scope of this non-compliance is isolated.
The severity of the non-compliance and the severity of the harm and risk of further harm is actual harm/risk.
The home does have a history of previous noncompliance unrelated.

(649)

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 : Sep 25, 2017

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. (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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that resident #041 is reassessed and the plan of care reviewed and revised at least every six months and at any other time when resident #041's care set out in the plan had not been effective.

The plan is to be submitted to janet.groux@ontario.ca by July 17, 2017.

Grounds / Motifs :

1. 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 care set out in the plan had not been effective.

Record review of a CI reported that resident #041 was found in an identified position at an identified date and time and had verbalized pain to an identified area of his/her body. The resident was transferred to the hospital for an assessment and was diagnosed with an identified injury to areas of his/her body.

Resident was not available for an interview.

Record review of resident #041's progress notes indicated resident #041 has an identified number of falls during an identified periods of time in 2016.

Record review of the resident's written plan of care dated during identified dates revealed that no new interventions were implemented when the resident continued to have falls during the identified time in 2016. The Director of Nursing #016 and #017 revealed that no assessment or reassessment had been completed during this period when resident continued to have falls. The Directors further revealed that resident #041's plan of care had not been updated or revised.

Interview with PT #007 revealed that resident #041 was not in any physiotherapy programs and he/she had not assessed resident after he/she started to have frequent falls during the identified times in 2016. The PT and RN #108 revealed that there had been monthly falls multidisciplinary meetings that are documented in PCC and revealed resident #041 had not been discussed at any of these meetings related to his/her falls.

Interview with the DRS revealed that no new interventions were documented or care plan revised after the resident started to have frequent falls during the identified times. [s. 6. (10)]

(649)

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 : Sep 25, 2017

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 soins 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 soins 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 23rd day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Janet Groux

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