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
Sep 7, 2016	2016_321501_0009	013789-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE WEXFORD RESIDENCE INC.
1860 Lawrence Avenue East TORONTO ON M1R 5B1

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

THE WEXFORD
1860 LAWRENCE AVENUE EAST SCARBOROUGH ON M1R 5B1

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

SUSAN SEMEREDY (501), ADAM DICKEY (643), ANGIE KING (644), GORDANA KRSTEVSKA (600), TILDA HUI (512)

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): May 11, 12, 13, 16, 17, 18, 19, 20, 24, 25, 26, 27, 30, 31, June 1, 2, 3, 6, 8, and 9, 2016.

The following complaints were inspected concurrently with this inspection: 003678-16 related to the prevention of falls; 032721-15 related to housekeeping; 009395-14 related to sufficient staffing; 006495-15 related to hospitalization and change in condition; 013678-16 related to Family Council, 013948-16 related to maintenance and 015653-16 related to personal support services.

The following critical incidents were inspected concurrently with this inspection: 001247-15, 008934-16, 030914-15, 006796-16, 015486-16, 016384-16, 016611-16, 016386-16 and 016640-16 related to the prevention of abuse and neglect; 003616-15 related to medication administration; 030906-15 and 013700-16 related to the prevention of falls; 016402-15 related to personal support services; and, 006712-14 and 008329-16 related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Nurse Managers (NM), Food Services Manager (FSM), Environmental Manager (EM), Social Worker (SW), Director of Programs and Services (DPS), Registered Dietitian (RD), Registered Physiotherapist (PT), Physiotherapy Assistants (PTA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides, Activationists, Housekeeping Aides, Resident Assessment Instrument (RAI) Coordinators, residents, students, physician, family members, Substitute Decision Makers (SDM), Family Council Chair and Vice-Chair, and Residents' Council President.

During the course of the inspection, the inspectors conducted observations in home and resident areas, observation of care delivery processes including medication passes and meal delivery services, and review of the home's policies and procedures, surveillance videos and residents' health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
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
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **20 WN(s)**
- **11 VPC(s)**
- **2 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. 36.	CO #001	2016_353589_0003	600
O.Reg 79/10 s. 68. (2)	CO #001	2015_321501_0008	501
O.Reg 79/10 s. 90. (2)	CO #002	2016_353589_0003	600

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 resident #061 was protected from physical abuse.

Physical abuse as outlined in section 2.(1) of the Regulation (O. Reg. 79/10) includes the use of physical force by anyone other than a resident, that causes physical injury or pain.

Review of a Critical Incident Report (CIR) revealed that on an identified date, PSW #146 observed PSW #151 forcing resident #061 to perform an identified activity of daily living even though the resident was refusing. PSW #151 insisted and forcefully directed the resident towards an identified room from his/her room. Resident #061 had responsive behaviours and ended up on the floor.

Record review of resident #061's written plan of care revealed he/she had a history of responsive behaviours. Staff were to provide non-care related conversation prior to attempting to provide assistance with activities of daily living. Review of progress notes revealed he/she had refused an identified activity of daily living on several occasions.

Interview with PSW #146 revealed he/she observed PSW #151 pull resident #061 towards an identified room against his/her will on an identified date. PSW #146 stated PSW #151 spoke to resident #061 in harsh tones, using inappropriate language. Resident #061 was observed resisting saying he/she did not want to perform the identified activity of daily living. PSW #151 continued to pull resident #061 toward the identified room even though he/she was resisting. PSW #146 was concerned for the safety of the resident and reported this incident immediately to the Co-ordinator of Staff Development.

Interview with an identified staff member revealed resident #061 came to their office that morning. Resident #061 was angry, complained that an identified body part hurt and stated that someone had pushed him/her to the ground.

Review of video surveillance from an identified date and time revealed PSW #151 was walking behind resident #061 from his/her room. Resident #061 turned away from the identified room door, and PSW #151 pulled him/her back in the direction of the identified room door. PSW #151 then took away resident #061's assistive device at which point resident #061 swung toward PSW #151. PSW #151 grabbed resident #061 by identified body parts and continued to lead him/her towards the identified room without his/her assistive device, despite his/her resistance. Resident #061 began to lean forward off balance while PSW #151 was pulling him/her towards the door. Resident #061 began to fall forward, and was then lowered to the floor near the doorway to the identified room. PSW #151 was then observed reaching toward the security keypad for the identified room door. PSW #151 and PSW #146 were then observed helping the resident up off the floor giving him/her his assistive device back.

Interview with PSW #151 revealed inconsistencies between his/her statements and the video surveillance of the incident. PSW #151 denied pulling resident #061 without his/her assistive device toward the identified room at any time. PSW #151 stated that he/she moved resident #061's assistive device in order to enter the door code for the identified room. He/she stated the resident then began to sink down, and was lowered to the floor. PSW #151 denied using inappropriate language with the resident. PSW #151 stated that he/she had not received retraining on the home's policies upon his/her return to work.

Interview with resident #061's SDM revealed he/she was not aware PSW #151 had returned to work at the home. Resident #061's SDM stated that he/she was not comfortable with PSW #151 caring for resident #061 in the future.

Review of a discipline letter to PSW #151 from the DOC revealed PSW #151 had been observed forcing resident #061 towards the identified room when he/she was refusing and pushing PSW #151 away. Before returning to work PSW #151 was to receive retraining on the home's policies on abuse and neglect, The Residents' Bill of Rights, and falls prevention.

Interview with the DOC on an identified date, confirmed that in this case resident #061 had been physically abused based on surveillance video of the incident. The DOC stated PSW #151 should not have returned to work prior to receiving retraining on the home's policies. He/she stated that PSW #151 would be monitored by the charge nurses, however PSW #151 had returned to work on an identified date, and the monitoring plan had not yet been communicated to the registered staff.

Interview with the ED confirmed PSW #151 should have received the above mentioned retraining and enhanced monitoring should have been organized prior to his/her return to work.

The severity of this noncompliance is actual harm as the resident suffered pain and as a result, a compliance order is warranted. [s. 19. (1)]

2. The licensee has failed to ensure that residents are not neglected by staff.

Neglect as outlined in section 2.(1) of the Regulation (O. Reg. 79/10) includes the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being.

Review of a Critical Incident Report revealed RN #144 entered the room of resident #041 to administer medication on an identified date. Resident #041's SDM stated that he/she had food in his/her mouth which RN #144 urged him/her to swallow. RN #144 was observed trying to get resident #041 to open his/her mouth and forced the medication spoon against his/her lips. RN #144 urged resident #041 to swallow repeatedly and performed an inappropriate action to induce swallowing.

Record review of resident #041's written plan of care revealed the resident had potential for choking due to an inability to chew and swallow food effectively. Staff were to feed resident slowly and not make him/her feel rushed.

Interview with resident #041's SDM revealed that on an identified date, while he/she was feeding the resident, RN #144 attempted to administer oral medication. The resident still had food in his/mouth and was not swallowing. In order to get the resident to swallow, RN #144 performed an inappropriate action to induce swallowing. The SDM stated this incident left him/her feeling upset and angry and indicated he/she felt RN #144 treated resident #041 in an abusive manner and was concerned he/she might choke.

Record review revealed the spouse sent the DOC an email regarding the situation in which he/she distinctly observed the resident being treated in an inappropriate manner. Interview with the DOC revealed RN #144 denied treating resident #041 inappropriately, stating that he/she did so only in order to wake him/her.

Interview with the DOC confirmed the home found the above mentioned actions of RN

#144 to be inappropriate and he/she was terminated. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

Review of complaint intake #006495-15 revealed a report from the resident's family that resident #031's altered skin integrity on an identified body part was noted to be infected when the resident was transferred to the hospital.

Review of resident #031's progress notes indicated the resident received a medical procedure on an identified date, performed at the home. The procedure resulted in altered skin integrity. There were physician's orders for the daily application of an

antibiotic cream to the altered skin integrity which was to be covered with a bandage for an identified time period.

Review of the electronic treatment record indicated the medicated cream was applied daily on identified dates.

Review of the resident's written plan of care did not reveal any focus, goal, and interventions developed to address the resident's altered skin integrity on or after an identified date when the medical procedure was performed.

Interviews with RPN #141 and #161, as well as RPN #129, who was the skin and wound lead, confirmed that there were no strategies set up to manage the resident's altered skin integrity on or after an identified date. Interview with the RD and the DOC confirmed the written plan of care did not include the above mentioned planned care for the resident. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the resident, the SDM, and any other persons designated by the resident or SDM were given the opportunity to participate fully in the development and implementation of the plan of care.

This finding is associated with complaint intake #006495-15 and a Critical Incident Report regarding the improper care provided to resident #031.

Review of progress notes for resident #031 revealed the resident was refusing medications and experiencing reduced fluid and food intake starting on an identified date. The resident continued to deteriorate in the next three days with minimal fluid and food intakes, and was noted with decreased level of consciousness. The resident was recorded as having low daily total fluid intake on identified dates, and the resident's documented food intake was minimal each meal on identified dates. The attending physician was notified on an identified date, and the resident was ordered to be transferred to hospital following an assessment by the physician.

Interview with the resident's relative who often visited the resident indicated the family was not informed about the resident's reduced fluid and food intake during the period of deterioration. The relative stated that one time he/she inquired about the resident's food intake during the above mentioned identified dates and was told by the RPN on duty that the RPN had fed the resident him/herself and that the resident had eaten most of his/her identified meal.

Interviews with RPN #142 and #163 indicated that the family were not contacted to provide accurate information on the fluid and food intake of the resident during the identified time period. Interview with RPN #129 revealed the resident had previous histories of refusing to eat and drink for a few days related to his/her medical condition but would improve and start eating and drinking again. RPN #129 stated that he/she did not contact the family nor the physician believing that the resident was going through the same phases as before of not eating and drinking. RPN #129 and #161 indicated that they usually documented in progress notes after they had spoken to a resident’s family member.

Review of the progress notes revealed there was no documentation by the RPNs to indicate the family was informed of resident #031's reduced fluid and food intakes during identified dates.

Interview with Nurse Manager #132 and the DOC confirmed that the resident's SDM or designate was not provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

3. 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.

Review of a Critical Incident Report revealed on an identified date and time, an identified staff member found resident #021 lying on the floor in his/her room. The resident sustained identified injuries. Emergency services was called, and prior to transfer to hospital, blood work indicated an abnormal result. The resident was treated by the emergency team and transferred to the hospital for treatment of an identified injury.

Review of resident #021's written plan of care identified the resident was at potential risk for complications related to a specified medical condition. The goal for prevention of complications was for resident to have no signs and symptoms for the next 90 days. Interventions planned to accomplish this goal were for staff to administer an identified medication as per physician’s order at identified times, perform blood work as per physician's orders, and ensure resident eats his/her meals and snacks.

Review of resident #021’s physician’s orders revealed if resident's blood work had an identified result, the physician was to be notified. Further the orders review revealed an identified medication to be administered at an identified time and another identified

medication to be given after meals.

Review of resident #021’s medication administration record (MAR) revealed on an identified date and time the resident’s blood work had the identified result and the resident had received a dose of an identified medication. Further MAR review revealed blood work had the identified result and at another identified time, the resident received the medication to be given after meals.

Review of the PSW food and fluid intake dated on the same identified date, revealed resident had zero intake for two consecutive meals.

Review of the resident's plan of care failed to reveal that staff had notified the physician for blood work of an identified result as indicated in the physician's order. Further record review revealed the plan of care indicated the identified medication was to be given after a meal however the resident had not eaten two consecutive meals and was still given the medication.

Interview with RPN #102 indicated the staff should be aware to hold the identified medication administration when blood work had the identified result. Also the RPN indicated the identified medication should have been held at an identified meal time because the resident did not eat at a previous identified meal time. The RPN confirmed the staff who checked resident #021's blood work did not notify the physician as was specified in the resident's plan of care.

Interview with Nurse Manager #120 confirmed the staff should not have administered the medication until the physician was notified of the identified result and had not eaten two meals in a row. [s. 6. (7)]

4. Record review of a Critical Incident Report and the home's internal investigation revealed on an identified date, resident #020 sustained an injury while being provided care by PSWs #115 and #152. That evening the resident had been having responsive behaviours and did not want to have an identified activity of daily living. At an identified time, PSWs #115 and #152 assisted the resident with an identified activity of daily living and took him/her to bed. PSW #152 went to perform an activity in the adjoining washroom while PSW #115 tried to provide care. At that point, the resident tried to lash out towards PSW #115. The resident accidently hit an identified object and sustained an injury. Resident #020's injury was profusely bleeding so he/she was transferred to the hospital for treatment.

Review of the CIR, interviews held with PSW #115 and PSW #152, and review of the progress notes from the incident report provided conflicting information regarding how and when the resident sustained an injury. PSW #115 revealed the resident had been upset all evening resisting care and refusing to go to bed, but finally he/she agreed. Two PSWs transferred resident #020 to bed and left him/her to sit on the edge of the bed. PSW #152 performed an activity in the adjoining washroom. When PSW #115 tried to provide care, the resident tried to resist and hit an identified object. Resident #020 sustained an injury that was bleeding. After the nurse assessed the resident, he/she was sent to hospital.

Interview with PSW #152 revealed the resident had been resistive to care, refused an identified activity of daily living earlier that evening and refused to go to bed. However, they had to complete assisting the resident to bed, as they had to look after the other residents who were waiting to be cared for. When they transferred the resident to bed, PSW #115 tried to remove identified pieces of clothing, PSW #152 performed another activity in the adjoining washroom and the resident, being already agitated lashed out, hit an identified object and injured self.

Review of progress notes dated on an identified date, revealed PSW #115 heard calls for help from resident #020's room. PSWs #115 and #152 had been found in the resident's room with resident crying and moaning. The progress note further revealed PSW #115 told the nurse resident #020 was resistive to go to bed, and when staff were transferring the resident to bed, the resident had not been cooperative and suddenly started shouting. When PSWs assessed the resident they observed an injury on an identified body part.

Review of resident #020's documentation record revealed the resident had experienced responsive behaviours and had been referred to specialized resources for assessments and follow ups. After assessment on an identified date, three days before the incident it was recommended when resident was resistant to care, the staff were to utilize strategies outlined in the plan of care and be cognizant that the resident had expressed that he/she would like staff to be careful during care.

Review of resident #020's written plan of care revealed goals and interventions for the staff to follow when providing care to resident #020. To reduce incidents of aggression and angry outburst and to ensure safety for the resident, staff were to recognize and avoid behaviors that provoke responsive behaviour by allowing resident time to respond

to directions, to approach the resident slowly and from the front, and to be cognizant of not invading resident's personal space. If resident #020 is upset, give him/her space and re-approach.

Interview with both PSWs confirmed they were aware one of the interventions when caring for resident with responsive behaviours was to leave the resident and re-approach him/her again later. They further confirmed they should have left the resident when he/she was agitated and tried to provide care later, when he/she had calmed down and agreed to cooperate with care. Further they confirmed the resident has the right to choose and if the resident refuses, they should leave him/her and reapproach later. Interview with Nurse Manager #132 confirmed staff should have left resident #020 when he/she was agitated and re-approach later when he/she had calmed down.

Interview with the DOC confirmed the staff had training regarding responsive behaviours and they were all aware of how to care for residents with responsive behaviours. The staff did not provide care to the resident #020 as specified in the written plan of care. [s. 6. (7)]

5. Review of a Critical Incident Report revealed resident #023 had a history of falls and had been identified to experience responsive behaviours and to be at high risk for falls. The resident was monitored for fall risk, and preventative measures were in place to prevent falls. He/she also had been referred to and followed up by specialized resources. The resident had been treated at an external facility regarding his/her responsive behaviour and he/she had been discharged from the facility on an identified date, a day before the fall. One to one monitoring had started once the resident was readmitted to the home to provide safety for him/her as well as other residents. On an identified date, resident #023 had a fall and sustained an injury when the PSW providing one to one monitoring left the resident unattended.

Interview with PSW #111 revealed he/she knew resident well and knew resident experienced responsive behaviours, had a history of falls and was identified at high risk of falls. After the resident's readmission, PSW #111 provided one to one monitoring care for him/her and made sure the falls prevention measures were in place. However, PSW #111 confirmed on the morning of an identified date, he/she left the resident unattended when he/she went to see the nurse in charge. When the PSW was at the nursing station talking to the nurse, the resident had a fall and sustained an injury.

Interview with NM #120 confirmed the resident was provided one to one care to provide

safety to the resident and other residents and should not be left alone. The staff had been aware to use a call bell if they needed to be replaced or to talk to someone. PSW #111 who did one to one care, should never have left resident #023 unattended. [s. 6. (7)]

6. Review of a Critical Incident Report revealed a suspected incident of abuse/neglect of resident #033 occurred on an identified date at an identified time. The resident was found in an identified room in a mechanical lift on a toilet. The resident was found unattended at the time and was not in any distress or discomfort. The resident was immediately released from the lift when found and sustained no injury. The RPN and two PSWs on duty rushed onto the scene when alerted by the staff who found the resident. The home initiated an investigation and conducted interviews with staff involved. The PSW who was responsible for the resident was interviewed and admitted transferring the resident using the lift alone by him/herself. The identified PSW indicated the resident was then left in the room unattended as he/she was called away to attend to another resident close by. The RPN and the second PSW on duty was not aware of the transfer as he/she was providing care to a resident inside the room. The identified PSW was disciplined following completion of the investigation.

Review of the resident's plan of care indicated the resident required two PSWs and a mechanical lift for assistance.

Interview with an identified staff member indicated he/she was conducting occupational health and safety rounds at the time of the incident and found the resident in an identified room unattended. Interview with RPN #122 who was on duty confirmed that resident #033's plan of care indicated two staff were required to transfer the resident using the mechanical lift. The RPN further indicated that he/she routinely reminded PSWs at the beginning of the shift that two staff were required to transfer residents by the mechanical lift. The RPN stated that he/she talked to the identified PSW after the incident and the PSW admitted transferring the resident alone by him/herself using the mechanical lift as the second PSW was busy with other residents. The identified PSW and the second PSW on duty were contacted several times and were not able to be reached for interview.

Interview with the DOC confirmed that the identified PSW was not providing care to the resident as specified in the plan of care.

The scope of this non compliance is a pattern as it relates to four residents. The severity

is actual harm as three residents sustained injury. The compliance history reveals findings related to LTCHA s.6(7) in the following reports: 2015_302600_0005 (written notification and voluntary plan of correction); 2015_321501_0005 (written notification and voluntary plan of correction); 2014_220111_0009 (written notification and compliance order); and 2013_195166_0043 (written notification and voluntary plan of correction). As a result of scope, severity and previous compliance history, a compliance order is warranted. [s. 6. (7)]

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Review of a Critical Incident Report revealed that on an identified date, PSW #146 observed PSW #151 pulling back resident #060's bed covers. Resident #060 made identified motions towards PSW #151 who then gave actual identified motions to identified areas on the resident's body.

Review of resident #060's medical record revealed the resident had a history of having responsive behaviours and making the specified gesture while staff attempted to provide care.

Review of a signed statement and interview with PSW #146 revealed PSW #151 insisted on getting resident #060 out of bed when the resident had repeatedly said no. While PSW #151 got him/her up out of bed, resident #060 gestured towards PSW #151 who grabbed the resident and actually performed the gesture to identified body areas. PSW #151 used a harsh tone of voice and said he/she didn't have time for this. PSW #146 was concerned for the safety of the resident and reported this incident immediately to the Co-ordinator of Staff Development.

Observation revealed there was no injury and the resident did not appear to be in any pain. Inspector tried to interview the resident however due the resident's cognitive status, he/she was unable to answer questions.

Interview with PSW #151 revealed resident #060 did not make any motions towards him/her that morning and that this was the action of another resident. Interview with the DOC revealed PSW #151 told him/her that resident #060 often made gestures towards him/her and staff would often joke around with him/her to get him/her to comply. The DOC confirmed PSW #151 had not listened to resident #060 and this was disrespectful. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

Review of a Family Council Action Form submitted to the home on an identified date, revealed there were concerns raised by a resident that the back garden patio was dangerous because the interlocking bricks were uneven which made it possible for residents to trip and fall and the slopes made it possible for residents to fall out of their wheelchairs. It was suggested that the home should improve the surface for better maneuvering of the wheelchairs and to avoid the possibility of residents sliding out of their wheelchairs.

Observations of the back patio revealed the bricks were uneven and there were some sloping areas.

Interview with resident #007 revealed he/she thought the area would be safer if paved with a smooth surface and evened out so there would be no slopes. He/she stated the area was unsafe because residents in wheelchairs with no seatbelts could fall out.

Interview with resident #042 revealed the bricks were uneven and bumpy which made it difficult for residents and family members to maneuver wheelchairs. Interview with resident #042's SDM revealed that one time when taking resident #042 for a walk out on the back patio, he/she almost fell out of his/her wheelchair when going down a slope.

Interview with the EM revealed that since the home had received this concern, he/she had received one quote to repair the back patio. Interview with the ED revealed the home would not be able to address the situation this year. The ED stated he/she would monitor the situation and hung a sign at the patio door that stated, "Please be aware that parts of the patio in the garden area may have uneven patio stones. Please report any areas with uneven patio stones to CEO & Executive Director." This sign did not address the sloping areas where residents could fall from their wheelchairs. [s. 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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors that residents do not have access to are kept closed and locked.

During the initial tour on May 11, 2016, inspector #516 observed the door to the dining room on an identified floor was ajar and there was access to the servery area with a steam table and dishwasher. The entrance to the servery had swinging doors with no locks. There were no residents or staff in the dining room at the time.

On May 12, 2016, inspectors #501, 643 and 644 observed the dining room on the same floor was unlocked and there were no residents or staff in the area. Inspectors found identified chemicals in the servery area including. On one of the carts was a pair of scissors. Interview with PSW #128 revealed this room should be locked for safety reasons. Interview with RPN #129 confirmed this door should be locked.

On May 26, 2016, inspector #501 observed the door to the dining room on the same floor was unlocked and the servery with the above mentioned chemicals were accessible. Interview with Nurse Manager #120 confirmed this door should be locked. [s. 9. (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 all doors that residents do not have access to are kept closed and locked, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observations made on an identified floor on May 11 and May 30, 2016, noted a suction machine stored on the top shelf of a cart outside the nursing station was dirty with debris and dust.

Interview with RPN #102 indicated the suction machine was supposed to be cleaned every week on Monday as scheduled. The RPN showed the cleaning schedule to inspector and revealed the machine had not been cleaned for past the past two Mondays. The RPN confirmed he/she did not clean the machine.

Interview with the DOC confirmed the suction machine should have been cleaned every Monday as scheduled. [s. 15. (2) (a)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

Observation on May 19, 2016, revealed the call bell in an identified room was not working. Interview with RPN #107 revealed he/she would call maintenance to report this. Interview with the EM revealed he/she received this report and he/she was waiting for a part to fix the call bell.

Observation on May 20, 2016, revealed the same call bell was still not working. Interview with PSW #108 revealed he/she was not aware of this but would report it. Interview with NM #132 revealed that the practice in the home is for staff to monitor more regularly the resident(s) whose call bell(s) are not working and this information is communicated during shift report. Further interview with PSW #108 revealed he/she was not informed during shift report on May 20, 2016, that resident #003 who resided in the identified room needed to be monitored more regularly because his/her call bell was not working as it was not discussed. [s. 17. (1) (a)]

2. Observation made on May 11, 2016, at 1000 hours noted the call bell in the activity room on an identified floor was installed on a wall. A flower box at table height surface sized four feet by two feet was noted placed in front of the wall with the call bell. Residents would not have been able to access the call bell which was the press button type with no cord attached.

Observations made on the same tour also noted call bells were installed in the lobbies, which were used as residents' lounges, on three identified floors, on walls outside the dining room. The call bells were observed blocked by the dining room doors when they were in open positions. Residents would not have been able to access the call bells which were the press button type with no cord attached.

Interviews with RPN #102 and #103 indicated the residents, either in wheelchairs or walking would not have been able to access the call bells in the above mentioned areas of the home. Interviews with the EM and the ED confirmed that the activity room on an identified floor and the call bells situated outside the dining rooms on three identified floors were not accessible to residents. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #8: 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 are documented.

Resident #001 had been triggered in stage one of the RQI inspection for altered skin integrity.

Review of resident #001's written plan of care revealed the resident had altered skin integrity to identified body areas. The goal set for this problem was the resident will show no signs of infection, show reduction in size of altered skin integrity, and will have no drainage from altered skin integrity areas. Intervention included in the plan of care for this goal was for personal support workers to turn and reposition the resident every two hours (q2h).

Interview with PSW #124 revealed residents who are at risk for skin impairment or have altered skin integrity are to be turned and repositioned every two hours and staff are to document in the flow sheet every time they reposition a resident. Further the PSW confirmed they had repositioned the resident q2h but documented only once per shift for each time they had repositioned the resident.

Review of the PSWs' documentation record titled Flow Sheet for March, April, and May, 2016, under the section titled "turned and repositioned q2 h" revealed staff had documented once per shift but had failed to document q2h after the repositioning occurred.

Interview with wound care nurse (WCN) #142 confirmed staff are expected to document in the flow sheet as soon as possible after the interventions had been completed. If the resident was to be repositioned every two hours, the staff are expected to reposition the resident every two hours and document after the intervention is completed.

Interview with the DOC confirmed staff are expected to follow the resident's written plan of care and document as soon as the intervention is provided. The registered staff should set up the time of the intervention in the plan of care for every two hours, so the intervention is flagged in the PSWs' flow sheets, and the action taken could then be documented. [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 #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Review of complaint intake #006495-15 revealed a report from the resident's family that when resident #031 was transferred to the hospital, his/her identified altered skin integrity was noted to be infected.

Review of resident #031's progress notes indicated the resident received a medical procedure on an identified date, performed at the home. The procedure resulted in altered skin integrity. Application of an antibiotic cream to the wound site daily and

covered with a bandage for an identified time period were ordered. Review of the electronic treatment record indicated the medicated cream was applied daily from an identified time period. The resident was transferred to hospital on an identified date due to deterioration in health status.

Review of resident #031's record revealed that no skin and wound assessment had been conducted for the resident's altered skin integrity on an identified body part on or after an identified date, when the medical procedure was performed.

Interviews with RPN #141 and #161, as well as RPN #129, who was the skin and wound lead, confirmed that there was no skin and wound assessment conducted for the resident on or after an identified date. Interview with the DOC confirmed that a skin and wound assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment should have been conducted for the resident. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who is a member of the staff of the home.

Review of complaint intake #006495-15 revealed a report from the resident's family that resident #031's altered skin integrity was noted to be infected when the resident was transferred to the hospital.

Review of resident #031's progress notes indicated the resident received a medical procedure on an identified date, performed at the home. The procedure resulted in altered skin integrity.

Record review for resident #031 revealed there was no referral to the Registered Dietitian (RD) regarding the resident's altered skin integrity on or after an identified date, when the medical procedure was performed.

Interviews with RPN #141 and #161, as well as RPN #129, who was the skin and wound lead, confirmed that there was no referral made to the RD for the resident's altered skin integrity on or after an identified date. Interview with the RD and the DOC confirmed that a referral to the RD should have been made in order for the RD to assess the resident's nutrition and hydration status with regards to altered skin integrity. [s. 50. (2) (b) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and is assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the home has a dining and snack service that includes proper techniques to assist residents with eating.

On an identified date, the inspector observed resident #029 being fed by PSW #100 in a dining room on an identified floor. The PSW was forcing food in the resident's mouth with a metal utensil, bringing the utensil in and out in a rapid manner. The utensil was full of food and would spill out of his/her mouth. The PSW scraped the food around the resident's mouth with the metal utensil. On two occasions the PSW was observed to offer the resident a drink from a specialized cup and whatever fluid leaked out of the resident's mouth, the PSW would scrape from resident's face with the cup and offer him/her to drink it again.

Interview with the PSW revealed resident #029 exhibited a particular behaviour when fed. The PSW initially denied the utensil was full of food, but then indicated he/she had to fill the utensil otherwise the resident would not have enough food intake. The PSW also showed the inspector that when the resident was fed in a slow manner, the resident would exhibit the behaviour

Review of resident #029's written plan of care revealed the resident required one staff limited assistance to feed the resident so he/she will maintain his/her adequate level of functioning. Staff were to provide a plastic utensil, no metal, and provide encouragement to the resident so he/she finished his/her meals.

Interview with the RD revealed resident #029 exhibited a particular behaviour when fed which had been occurring for some time. The intervention provided to address this problem was to use a plastic utensil but it seemed this had not helped and a plan to address the issue had not been documented. Further the RD revealed he/she was not aware what techniques the PSWs used when feeding the resident.

The RD observed the staff feeding resident #029 after the incident and identified a proper technique of how the staff should feed the resident. The RD indicated the staff should feed the resident with a small amount of food on a plastic utensil and to turn the utensil upside down once the utensil entered resident's mouth.

Interview with the DOC confirmed staff did not use proper techniques to assist resident #029 with eating when he/she required assistance. [s. 73. (1) 10.]

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 the home has a dining and snack service that includes proper techniques to assist residents with eating, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances were kept inaccessible to residents at all times.

Observation on May 31, 2016, at 1115 hours on an identified floor revealed a housekeeping cart unattended in the hallway outside the locked dining room. The inspector walked up beside the cart and noted the door of the chemical compartment was unlocked and left half open. The inspector waited at the cart and met PSW #123 who indicated the housekeeping staff was mopping the floor in the dining room. The PSW opened the door and called the housekeeping aide to come out to speak to the inspector. Housekeeping Aide #136 came out of the dining room.

Interview with Housekeeping Aide #136 confirmed that he/she did not lock the chemical compartment door on the cart. Interview with the EM confirmed that the chemical compartment door on the housekeeping cart should be locked when unattended to prevent residents' access to the chemicals. [s. 91.]

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 all hazardous substances were kept inaccessible to residents at all times, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision maker was notified immediately upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident.

Review of resident #061's record revealed that he/she had two SDMs who were the resident's family members.

Interview with the Staff Education Coordinator revealed PSW #146 had reported to him/her an incident of alleged staff to resident abuse of resident #061 on an identified date. The Staff Education Coordinator then contacted the DOC regarding these allegations.

Review of the home's investigation notes revealed the DOC was aware of these allegations on an identified date, and had begun investigating the incident.

Review of progress notes from an identified date and time, revealed resident #061 had gone to an identified staff member's office complaining he/she was pushed, got hurt and was holding an identified body part. Resident #061's spouse who is not a SDM was contacted in order to help get him/her to settle down following the incident.

Interview with one of resident #061's SDMs on an identified date, revealed that he/she had not been notified that the incident that occurred on an identified date, was being investigated as alleged abuse. The SDM was quite upset and indicated that the other SDM had not been notified either.

Interview with the DOC on an identified date, revealed RPN #103 had attempted to contact resident #061's SDM but was unable to reach him/her at that time. The DOC stated he/she wanted to gather more information prior to speaking with resident #061's SDM. He/she confirmed that resident #061's SDM had not been notified immediately of the witnessed incident of physical abuse of the resident. [s. 97. (1) (a)]

2. The licensee has failed to ensure that the resident and the resident's substitute decision maker were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

Review of a discipline letter to PSW #151 with an identified date, revealed the DOC had concluded the alleged abuse investigation regarding resident #061 and disciplinary action was appropriate in this case.

Interview with resident #061's SDM on an identified date, revealed he/she was not notified immediately upon the completion of the investigation into a witnessed incident of abuse. He/she stated that the home did not notify him/her of the results of the investigation at that time. He/ she had not been made aware that the investigation had been completed by the DOC and that PSW #151 had been disciplined as a result of the incident.

Interview with the DOC revealed that he/she was aware of the requirement to notify the resident #061's SDM of the results of the investigation and confirmed resident #061's SDM had not been notified immediately upon the completion of the investigation. He/she stated that he/she was out of the office and had not had time to contact the SDM with the results immediately upon completion of the investigation. [s. 97. (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 the resident's substitute decision maker is notified immediately upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident and the resident and the resident's substitute decision maker is notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131 (4.1) A member of the registered nursing staff may permit a nursing student to administer drugs to residents if,
(a) the licensee has verified with the university or college that offers the nursing educational program in which the nursing student is enrolled that the nursing student has received education or training about the administration of drugs as part of the program;
(b) the nursing student has been trained by a member of the registered nursing staff in the written policies and protocols for the medication management system referred to in subsection 114 (2);
(c) the member of the registered nursing staff who is permitting the administration is satisfied that the nursing student can safely administer drugs; and
(d) the nursing student who administers the drugs does so under the supervision of the member of the registered nursing staff.

Findings/Faits saillants :

1. The licensee has failed to ensure that a member of the registered nursing staff who permits a nursing student to administer drugs to residents, does so under the supervision of the member of the registered nursing staff.

Review of a Critical Incident Report revealed resident #021 had a fall and sustained injuries. Emergency services had been called and prior to transfer to the hospital, blood work revealed an abnormal result. The resident was treated by the emergency team and transferred to the hospital for treatment of an identified injury.

Review of the staffing record indicated that at the time of the incident, a student nurse had been assigned to that floor. Review of resident #021’s medication administration record (MAR) and progress notes revealed on an identified date, when the incident happened a student nurse had been completing the resident's blood work and administering an identified medication.

Interview with RPN #102 revealed he/she had been assigned a student during an identified time period. The RPN indicated that he/she usually supervises students but admitted he/she had not supervised this particular student while he/she checked resident #021's blood work or administered medication at identified times. The RPN also indicated he/she was not aware of the result of the blood work and the administration of the medication on an identified date, before the resident had a fall and sustained injuries. The RPN acknowledged that he/she should have supervised the student and his/her provision of care. Further he/she confirmed if he/she had supervised the student, he/she would have been aware of the identified result, held the medication and notified the physician.

Interview with the DOC confirmed the registered staff in role of preceptors are expected to train, educate and supervise student nurses. [s. 131. (4.1) (d)]

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 member of the registered nursing staff who permits a nursing student to administer drugs to residents, does so under the supervision of the member of the registered nursing staff, to be implemented voluntarily.

WN #14: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

On an identified date, the inspector observed medication administration and inspected narcotic boxes on identified floors. Review of the narcotic individual monitored record revealed RPN #124 on an identified floor and RPN #155 on another floor had not signed off the narcotic and/or controlled drugs in individual narcotic monitored records after they had administered narcotics and controlled drugs that morning.

Observation of the narcotic box revealed the following:
Resident #027- Clonazepam 0.5 milligrams(mg) individual monitored record showed 14 tablets (tbls) but medication card showed 12 tbls in the blisters.
Resident #028 -Tylenol #2 individual monitored record showed 56 tbls but there were 52

tbls in the card.
Resident # 064 - Oxycodone individual monitored sheet showed 6 tbls but the count is 5tbls in the card.
Resident # 062 - Hydromorphine contin CR4.5 mg individual monitored sheet showed12 tbls but there were 11 tbls in the card.
Hydromorphine contin CR3 mg individual monitored sheet showe12 tbls but there were 11 tbls in the card.
Resident # 063-Hydromorphone 1mg (1/2 tablet =0.5mg) individual monitored sheet showed 2.0 mg – but there were 1.5 mg in 3 (1/2 tablet =0.5mg) tbls in the card.

Interview with RPNs # 155 and #124 revealed they were aware the home expectation was to sign the narcotics off in the individual narcotic monitored record after medication have been administered to the resident but they did not sign the individual monitored record in the morning or at noon time after they have administered the medications to the identified residents. They indicated they were going to sign the record later on once they finished all medication administration.

Review of the home's policy #G-45 titled "Medication Administration" reviewed March 1, 2016, and pharmacy policy #6-5 titled "Individual Monitored Medication Record" dated January 2014, revealed the narcotic and controlled drug record will be maintained and the staff are to sign the individual monitored medication record each time the dose is administered, including the date, time, amount given, amount wasted and new quantity remaining.

Interview with NM #132 confirmed the staff are expected and must sign off in individual narcotic record right after the medication is administered to the resident.

Interview with the DOC also confirmed that registered nursing staff had education about the policy for medication administration and they must sign off the narcotic medication as required by the policy. [s. 8. (1) (b)]

WN #15: 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 policy to promote zero tolerance of abuse and neglect of residents is complied with.

The home's policy #6.46 titled "Zero Tolerance of Abuse and Neglect of Residents" reviewed March 30, 2016, states that all staff are required to fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the Ministry of Health and Long Term Care. All staff are required to immediately report to the appropriate supervisor in home on duty at the time of a witnessed or alleged incident of abuse or neglect.

Interview with an identified staff member revealed resident #061 came to their office on an identified date, was holding an identified body area and repeating that someone had pushed him/her down to the floor. The staff member indicated that he/she did not immediately report this information thinking it was the responsibility of RPN #103 who was in charge of the unit.

Interview with RPN #103 revealed that at that time he/she was not aware that resident #061 had had a fall.

Review of an email revealed the identified staff member reported the incident to the DOC, the morning after the incident. Interview with the DOC confirmed the staff member should have immediately reported the incident. [s. 20. (1)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to immediately forward a written complaint that was received concerning the care of a resident to the Director.

Record review of the home's Internal Complaint Documentation Form revealed the home received a written complaint concerning the care of resident #043 on an identified date. Review of the complaint letter revealed the family was upset that there was poor communication within the home which impacted a scheduled medical procedure for resident #043.

Interview with the DOC revealed he/she thought the ED had forwarded the complaint letter to the Director before he/she received a copy. Interview with the ED revealed he/she thought the DOC forwarded the complaint to the Director. Interview with the DOC and review of the records regarding this complaint revealed the letter was emailed along with their internal documentation to the Director on an identified date, which was nine days after receiving it. [s. 22. (1)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

Interview with the Family Council Chair and Vice-Chair revealed that the Family Council had questions and concerns regarding a Ministry of Health and Long Term Care Inspection Report #2016_353589-0003 dated February 7, 2016, as well as, other miscellaneous concerns and did not receive a response.

Interview with the Family Council Assistant revealed he/she received these questions and concerns via email on April 14, 2016, from the Family Council Chair and were forwarded to the CEO on the same day.

Interview with the ED revealed he/she did not respond in writing to these concerns because he/she did not believe such information was appropriate to be shared with the Family Council. The ED confirmed he/she could have responded in writing that such information was not suitable to be shared but had failed to do so. [s. 60. (2)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey.

Interview with the Family Council Chair and Vice-Chair revealed that the Family Council had asked for a question to be added to the satisfaction survey during the Family Council meeting on October 20, 2016.

Review of the Family Council meeting minutes for October 20, 2016, revealed that a family member had suggested a question be added to the survey regarding communication from family members being passed on to staff members. The minutes revealed that the ED responded that he/she would re-write the question and send the revamped question back to the Family Council for approval.

Interview with another member of the Family Council revealed he/she remembered this discussion taking place during the meeting on October 20, 2015.

Interview with the ED revealed he/she did not recall receiving or discussing the above mentioned question and therefore did not submit the above mentioned question to be included in the satisfaction survey. [s. 85. (3)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for cleaning the home, including common areas and staff areas, including furnishings.

Observations on an identified floor on May 11 and May 30, 2016, noted a nurse's chair in the hallway dirty on the back of the chair. A resident lounge chair in the hallway outside an identified room was noted to be dirty with dirt debris on the seat and the chair legs.

Interview with Housekeeping Aide #130 and the EM confirmed the home did not have a cleaning schedule for the chairs including the nurses' chairs and resident lounge chairs. The night janitor was expected to clean the chairs when dirty. [s. 87. (2) (a)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

Observation made on an identified date at an identified time on an identified floor noted the shower room door with a sign that said "vacant". Inspectors #512 and 644 knocked on the door. PSW #100 answered the knock from inside the shower room and opened the door with two gloved hands. The PSW stated he/she was giving a shower to a resident inside and proceeded to change door sign from "vacant" to "occupied" with his/her left hand in gloves and was holding a piece of tissue paper. Inspector #512 asked the PSW if he/she had been using the gloves on his/her hands to provide shower to the resident inside. PSW stated yes and proceeded to remove the gloves and discarded them. The PSW agreed that he/she should have removed the soiled gloves before touching the door.

Interviews with the infection prevention and control program lead and the DOC confirmed that the PSW should not touch furnishings with used gloves on. [s. 229. (4)]

2. Observation made on an identified date and time on an identified floor which had a declared outbreak since an identified date, noted seven residents line-listed and isolated. Among the line-listed residents, two identified rooms were noted with personal protective equipment (PPE) in special bags hung on doors but no precaution signs.

Interview with RN #110 confirmed the resident in one of the identified rooms was on droplet precaution, and the resident in the other room had no contact precautions. The RN stated precaution signs should have been placed on the residents' doors together with the PPE. The RN stated he/she will check and replace the signs on the residents' doors.

Interviews with the infection prevention and control program lead and the DOC confirmed precautions signs should have been placed on doors of the residents who were in isolation. [s. 229. (4)]

3. Observation made on an identified date and time revealed an unlabelled hair comb on a handrail ledge in a hallway outside the shower room.

Interview with PSW #110 who was coming out from the shower room at the time, indicated the hair comb may belong to another resident who had a shower this morning. PSW indicated the hair comb should be labelled and he/she would take the comb and get it labelled.

Interviews with the infection prevention and control program lead and the DOC confirmed the hair comb should have been labeled for the resident's use. [s. 229. (4)]

Issued on this 13th day of September, 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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN SEMEREDY (501), ADAM DICKEY (643), ANGIE KING (644), GORDANA KRSTEVSKA (600), TILDA HUI (512)
Inspection No. / No de l'inspection :	2016_321501_0009
Log No. / Registre no:	013789-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 7, 2016
Licensee / Titulaire de permis :	THE WEXFORD RESIDENCE INC. 1860 Lawrence Avenue East, TORONTO, ON, M1R-5B1
LTC Home / Foyer de SLD :	THE WEXFORD 1860 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1R-5B1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SANDY BASSETT

To THE WEXFORD RESIDENCE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents are protected from abuse and neglect. The plan shall include, but not be limited to the following:

The development and implementation of:
1) A system of ongoing monitoring to ensure staff are complying with the home's policy and procedures related to zero tolerance of abuse and neglect.
2) A system to ensure SDMs are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect that has resulted in physical injury or pain to the resident or that causes distress to the resident.
3) A system to ensure that residents and/or SDMs are notified of the results of the alleged abuse or neglect investigation immediately upon the completion.
4) A system to ensure that all staff understand the training provided regarding the home's policy of zero tolerance of abuse and neglect, Residents' Bill of Rights, mandatory reporting and whistle blowing protection.
5) A system to ensure staff returning to work after being disciplined for abuse or neglect are given retraining in the above mentioned areas and are monitored closely when interacting with residents.

For all the above, as well as for any other elements included in the plan, please include who will be responsible for implementing, as well as a timeline for achieving compliance, for each part of the plan.

This plan is to be submitted via email to inspector adam.dickey@ontario.ca by September 22, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are not neglected by staff.

Neglect as outlined in section 2.(1) of the Regulation (O. Reg. 79/10) includes the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being.

Review of a Critical Incident Report revealed RN #144 entered the room of resident #041 to administer medication on an identified date. Resident #041's SDM stated that he/she had food in his/her mouth which RN #144 urged him/her to swallow. RN #144 was observed trying to get resident #041 to open his/her mouth and forced the medication spoon against his/her lips. RN #144 urged resident #041 to swallow repeatedly and performed an inappropriate action to induce swallowing.

Record review of resident #041's written plan of care revealed the resident had potential for choking due to an inability to chew and swallow food effectively. Staff were to feed resident slowly and not make him/her feel rushed.

Interview with resident #041's SDM revealed that on an identified date, while he/she was feeding the resident, RN #144 attempted to administer oral medication. The resident still had food in his/mouth and was not swallowing. In order to get the resident to swallow, RN #144 performed an inappropriate action to induce swallowing. The SDM stated this incident left him/her feeling upset and angry and indicated he/she felt RN #144 treated resident #041 in an abusive manner and was concerned he/she might choke.

Record review revealed the spouse sent the DOC an email regarding the situation in which he/she distinctly observed the resident being treated in an inappropriate manner. Interview with the DOC revealed RN #144 denied treating resident #041 inappropriately, stating that he/she did so only in order to wake him/her.

Interview with the DOC confirmed the home found the above mentioned actions of RN #144 to be inappropriate and he/she was terminated. (501)

2. The licensee has failed to ensure that resident #061 was protected from physical abuse.

Physical abuse as outlined in section 2.(1) of the Regulation (O. Reg. 79/10) includes the use of physical force by anyone other than a resident, that causes physical injury or pain.

Review of a Critical Incident Report (CIR) revealed that on an identified date, PSW #146 observed PSW #151 forcing resident #061 to perform an identified activity of daily living even though the resident was refusing. PSW #151 insisted and forcefully directed the resident towards an identified room from his/her room. Resident #061 had responsive behaviours and ended up on the floor.

Record review of resident #061's written plan of care revealed he/she had a history of responsive behaviours. Staff were to provide non-care related conversation prior to attempting to provide assistance with activities of daily living. Review of progress notes revealed he/she had refused an identified activity of daily living on several occasions.

Interview with PSW #146 revealed he/she observed PSW #151 pull resident #061 towards an identified room against his/her will on an identified date. PSW #146 stated PSW #151 spoke to resident #061 in harsh tones, using inappropriate language. Resident #061 was observed resisting saying he/she did not want to perform the identified activity of daily living. PSW #151 continued to pull resident #061 toward the identified room even though he/she was resisting. PSW #146 was concerned for the safety of the resident and reported this incident immediately to the Co-ordinator of Staff Development.

Interview with an identified staff member revealed resident #061 came to their office that morning. Resident #061 was angry, complained that an identified body part hurt and stated that someone had pushed him/her to the ground.

Review of video surveillance from an identified date and time revealed PSW #151 was walking behind resident #061 from his/her room. Resident #061 turned away from the identified room door, and PSW #151 pulled him/her back in the direction of the identified room door. PSW #151 then took away resident #061's assistive device at which point resident #061 swung toward PSW #151. PSW #151 grabbed resident #061 by identified body parts and continued to lead him/her towards the identified room without his/her assistive device, despite his/her resistance. Resident #061 began to lean forward off balance while PSW #151 was pulling him/her towards the door. Resident #061 began to fall

forward, and was then lowered to the floor near the doorway to the identified room. PSW #151 was then observed reaching toward the security keypad for the identified room door. PSW #151 and PSW #146 were then observed helping the resident up off the floor giving him/her his assistive device back.

Interview with PSW #151 revealed inconsistencies between his/her statements and the video surveillance of the incident. PSW #151 denied pulling resident #061 without his/her assistive device toward the identified room at any time. PSW #151 stated that he/she moved resident #061's assistive device in order to enter the door code for the identified room. He/she stated the resident then began to sink down, and was lowered to the floor. PSW #151 denied using inappropriate language with the resident. PSW #151 stated that he/she had not received retraining on the home's policies upon his/her return to work.

Interview with resident #061's SDM revealed he/she was not aware PSW #151 had returned to work at the home. Resident #061's SDM stated that he/she was not comfortable with PSW #151 caring for resident #061 in the future.

Review of a discipline letter to PSW #151 from the DOC revealed PSW #151 had been observed forcing resident #061 towards the identified room when he/she was refusing and pushing PSW #151 away. Before returning to work PSW #151 was to receive retraining on the home's policies on abuse and neglect, The Residents' Bill of Rights, and falls prevention.

Interview with the DOC on an identified date, confirmed that in this case resident #061 had been physically abused based on surveillance video of the incident. The DOC stated PSW #151 should not have returned to work prior to receiving retraining on the home's policies. He/she stated that PSW #151 would be monitored by the charge nurses, however PSW #151 had returned to work on an identified date, and the monitoring plan had not yet been communicated to the registered staff.

Interview with the ED confirmed PSW #151 should have received the above mentioned retraining and enhanced monitoring should have been organized prior to his/her return to work.

The severity of this noncompliance is actual harm as the resident suffered pain and as a result, a compliance order is warranted.

(643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

Order # / Ordre no : 002

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

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 prepare, submit and implement a plan to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. The plan shall include, but not be limited to the following:

The development and implementation of:
1) A process to monitor and audit all staff providing direct care to residents that will ensure the plan of care is being followed.
2) A process to ensure that student nurses are closely supervised during medication administration.
3) A process to ensure that staff providing one to one care for residents never leave the resident unattended.
4) A system to monitor residents who require more than one staff member for transfer are provided those staff members for all transfers.
5) A system to ensure those providing direct care for residents are knowledgeable about each plan of care, especially for those residents who are resistive to care.

For all the above, as well as for any other elements included in the plan, please include who will be responsible for implementing, as well as a timeline for achieving compliance, for each part of the plan. This plan is to be submitted via email to inspector susan.semeredy@ontario.ca by September 22, 2016.

Grounds / Motifs :

1. Review of a Critical Incident Report revealed a suspected incident of abuse/neglect of resident #033 occurred on an identified date at an identified time. The resident was found in an identified room in a mechanical lift on a toilet. The resident was found unattended at the time and was not in any distress or

discomfort. The resident was immediately released from the lift when found and sustained no injury. The RPN and two PSWs on duty rushed onto the scene when alerted by the staff who found the resident. The home initiated an investigation and conducted interviews with staff involved. The PSW who was responsible for the resident was interviewed and admitted transferring the resident using the lift alone by him/herself. The identified PSW indicated the resident was then left in the room unattended as he/she was called away to attend to another resident close by. The RPN and the second PSW on duty was not aware of the transfer as he/she was providing care to a resident inside the room. The identified PSW was disciplined following completion of the investigation.

Review of the resident's plan of care indicated the resident required two PSWs and a mechanical lift for assistance.

Interview with an identified staff member indicated he/she was conducting occupational health and safety rounds at the time of the incident and found the resident in an identified room unattended. Interview with RPN #122 who was on duty confirmed that resident #033's plan of care indicated two staff were required to transfer the resident using the mechanical lift. The RPN further indicated that he/she routinely reminded PSWs at the beginning of the shift that two staff were required to transfer residents by the mechanical lift. The RPN stated that he/she talked to the identified PSW after the incident and the PSW admitted transferring the resident alone by him/herself using the mechanical lift as the second PSW was busy with other residents. The identified PSW and the second PSW on duty were contacted several times and were not able to be reached for interview.

Interview with the DOC confirmed that the identified PSW was not providing care to the resident as specified in the plan of care. (512)

2. Review of a Critical Incident Report revealed resident #023 had a history of falls and had been identified to experience responsive behaviours and to be at high risk for falls. The resident was monitored for fall risk, and preventative measures were in place to prevent falls. He/she also had been referred to and followed up by specialized resources. The resident had been treated at an external facility regarding his/her responsive behaviour and he/she had been discharged from the facility on an identified date, a day before the fall. One to one monitoring had started once the resident was readmitted to the home to

provide safety for him/her as well as other residents. On an identified date, resident #023 had a fall and sustained an injury when the PSW providing one to one monitoring left the resident unattended.

Interview with PSW #111 revealed he/she knew resident well and knew resident experienced responsive behaviours, had a history of falls and was identified at high risk of falls. After the resident's readmission, PSW #111 provided one to one monitoring care for him/her and made sure the falls prevention measures were in place. However, PSW #111 confirmed on the morning of an identified date, he/she left the resident unattended when he/she went to see the nurse in charge. When the PSW was at the nursing station talking to the nurse, the resident had a fall and sustained an injury.

Interview with NM #120 confirmed the resident was provided one to one care to provide safety to the resident and other residents and should not be left alone. The staff had been aware to use a call bell if they needed to be replaced or to talk to someone. PSW #111 who did one to one care, should never have left resident #023 unattended. (600)

3. Record review of a Critical Incident Report and the home's internal investigation revealed on an identified date, resident #020 sustained an injury while being provided care by PSWs #115 and #152. That evening the resident had been having responsive behaviours and did not want to have an identified activity of daily living. At an identified time, PSWs #115 and #152 assisted the resident with an identified activity of daily living and took him/her to bed. PSW #152 went to perform an activity in the adjoining washroom while PSW #115 tried to provide care. At that point, the resident tried to lash out towards PSW #115. The resident accidently hit an identified object and sustained an injury. Resident #020's injury was profusely bleeding so he/she was transferred to the hospital for treatment.

Review of the CIR, interviews held with PSW #115 and PSW #152, and review of the progress notes from the incident report provided conflicting information regarding how and when the resident sustained an injury. PSW #115 revealed the resident had been upset all evening resisting care and refusing to go to bed, but finally he/she agreed. Two PSWs transferred resident #020 to bed and left him/her to sit on the edge of the bed. PSW #152 performed an activity in the adjoining washroom. When PSW #115 tried to provide care, the resident tried to resist and hit an identified object. Resident #020 sustained an injury that was

bleeding. After the nurse assessed the resident, he/she was sent to hospital.

Interview with PSW #152 revealed the resident had been resistive to care, refused an identified activity of daily living earlier that evening and refused to go to bed. However, they had to complete assisting the resident to bed, as they had to look after the other residents who were waiting to be cared for. When they transferred the resident to bed, PSW #115 tried to remove identified pieces of clothing, PSW #152 performed another activity in the adjoining washroom and the resident, being already agitated lashed out, hit an identified object and injured self.

Review of progress notes dated on an identified date, revealed PSW #115 heard calls for help from resident #020's room. PSWs #115 and #152 had been found in the resident's room with resident crying and moaning. The progress note further revealed PSW #115 told the nurse resident #020 was resistive to go to bed, and when staff were transferring the resident to bed, the resident had not been cooperative and suddenly started shouting. When PSWs assessed the resident they observed an injury on an identified body part.

Review of resident #020's documentation record revealed the resident had experienced responsive behaviours and had been referred to specialized resources for assessments and follow ups. After assessment on an identified date, three days before the incident it was recommended when resident was resistant to care, the staff were to utilize strategies outlined in the plan of care and be cognizant that the resident had expressed that he/she would like staff to be careful during care.

Review of resident #020's written plan of care revealed goals and interventions for the staff to follow when providing care to resident #020. To reduce incidents of aggression and angry outburst and to ensure safety for the resident, staff were to recognize and avoid behaviors that provoke responsive behaviour by allowing resident time to respond to directions, to approach the resident slowly and from the front, and to be cognizant of not invading resident's personal space. If resident #020 is upset, give him/her space and re-approach.

Interview with both PSWs confirmed they were aware one of the interventions when caring for resident with responsive behaviours was to leave the resident and re-approach him/her again later. They further confirmed they should have left the resident when he/she was agitated and tried to provide care later, when

he/she had calmed down and agreed to cooperate with care. Further they confirmed the resident has the right to choose and if the resident refuses, they should leave him/her and reapproach later. Interview with Nurse Manager #132 confirmed staff should have left resident #020 when he/she was agitated and re-approach later when he/she had calmed down.

Interview with the DOC confirmed the staff had training regarding responsive behaviours and they were all aware of how to care for residents with responsive behaviours. The staff did not provide care to the resident #020 as specified in the written plan of care.
(600)

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.

Review of a Critical Incident Report revealed on an identified date and time, an identified staff member found resident #021 lying on the floor in his/her room. The resident sustained identified injuries. Emergency services was called, and prior to transfer to hospital, blood work indicated an abnormal result. The resident was treated by the emergency team and transferred to the hospital for treatment of an identified injury.

Review of resident #021's written plan of care identified the resident was at potential risk for complications related to a specified medical condition. The goal for prevention of complications was for resident to have no signs and symptoms for the next 90 days. Interventions planned to accomplish this goal were for staff to administer an identified medication as per physician's order at identified times, perform blood work as per physician's orders, and ensure resident eats his/her meals and snacks.

Review of resident #021's physician's orders revealed if resident's blood work had an identified result, the physician was to be notified. Further the orders review revealed an identified medication to be administered at an identified time and another identified medication to be given after meals.

Review of resident #021's medication administration record (MAR) revealed on an identified date and time the resident's blood work had the identified result and the resident had received a dose of an identified medication. Further MAR review revealed blood work had the identified result and at another identified

time, the resident received the medication to be given after meals.

Review of the PSW food and fluid intake dated on the same identified date, revealed resident had zero intake for two consecutive meals.

Review of the resident's plan of care failed to reveal that staff had notified the physician for blood work of an identified result as indicated in the physician's order. Further record review revealed the plan of care indicated the identified medication was to be given after a meal however the resident had not eaten two consecutive meals and was still given the medication.

Interview with RPN #102 indicated the staff should be aware to hold the identified medication administration when blood work had the identified result. Also the RPN indicated the identified medication should have been held at an identified meal time because the resident did not eat at a previous identified meal time. The RPN confirmed the staff who checked resident #021's blood work did not notify the physician as was specified in the resident's plan of care.

Interview with Nurse Manager #120 confirmed the staff should not have administered the medication until the physician was notified of the identified result and had not eaten two meals in a row.

The scope of this non compliance is a pattern as it relates to four residents. The severity is actual harm as three residents sustained injury. The compliance history reveals findings related to LTCHA s.6(7) in the following reports: 2015_302600_0005 (written notification and voluntary plan of correction); 2015_321501_0005 (written notification and voluntary plan of correction); 2014_220111_0009 (written notification and compliance order); and 2013_195166_0043 (written notification and voluntary plan of correction). As a result of scope, severity and previous compliance history, a compliance order is warranted. (600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

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

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 7th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Semeredy

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