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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 12, 2017	2017_673554_0017	009577-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

WINBOURNE PARK
1020 Westney Road North AJAX ON L1T 4K6

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

KELLY BURNS (554), CRISTINA MONTOYA (461), JENNIFER BATTEN (672), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 04-07, and July 10-14, 2017

Resident Quality Inspection (RQI) #009577-17. The following intakes were inspected concurrently with the RQI, intakes #034435-16, 035404-16, 001348-17, 007258-17, 008653-17, 009139-17, 009817-17, 012251-17, 011758-17, and 015387-17.

Summary of Intakes:

1) #034435-16 - Critical Incident Report (CIR), alleged resident to resident physical abuse;
2) #035404-16 - CIR, incident that causes an injury to a resident for which resident is taken to hospital and which results in a significant change in resident's health status;
3) #001348-17 - CIR, alleged resident to resident verbal and physical abuse;
4) #007258-17 - CIR, alleged staff to resident physical abuse;
5) #008653-17 - CIR, incident that causes an injury to a resident for which resident is taken to hospital and which results in a significant change in resident's health status;
6) #009139-17 - CIR, alleged resident to resident physical abuse;
7) #009817-17 - CIR, incident that causes an injury to a resident for which resident is taken to hospital and which results in a significant change in resident's health status;
8) #012251-17 - Complaint, specific to, continence care, skin and wound care management;
9) #011758-17 - CIR, incident that causes an injury to a resident for which resident is taken to hospital and which results in a significant change in resident's health status;
10) #015387-17 - CIR, alleged resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Resident Care Coordinator/Staff Educator, Clinical Manager, Documentation Nurse, Office Manager, Environmental Services Manager, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Recreation Aide, Housekeeping Aide, Regional Manager of Educational Services, President of Resident Council , President of Family Council, Families and residents.

During the course of the inspection, the inspectors, toured the home, observed dining and snack service, observed resident to resident interactions, and staff to resident interactions; reviewed clinical health records, Resident Council Meeting Minutes, licensee’s investigational notes, the Physiotherapy Outcome Measures and Falls Prevention Report (ending date of March 31, 2017), Staffing Plans for 2016-2017; and reviewed licensee policies, specifically, PSW/HCA Admission Checklist for First 24 Hours, Falls Prevention and Injury Reduction Program, LTC-Falls Prevention, LTC-Post Falls Management, LTC-Head Injury Routine, LTC-Personal Assistance Services Device, Infection Prevention and Control Program,

Routine Practices and Additional Precautions, Infection Surveillance Protocols, Outbreak Management Protocols, Cleaning and Disinfecting Procedures, and Locations for Hand Sanitizer Stations, LTC Medication Incidents, LTC-Self-Administration of Medications, Resident Non-Abuse Program, Mandatory Reporting of Resident Abuse and Neglect, LTC-Investigation of Abuse or Neglect, LTC-Interventions for Victims of Abuse or Neglect, and LTC-Dementia Care Program.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee failed to ensure that there is a written plan of care for resident #010 that sets out, the planned care for the resident.

Resident #010 has a history which includes, cognitive and physical limitations. Resident #010 is dependent on staff for activities of daily living.

Resident #010 was observed, by Inspector #554 on identified dates, seated in a tilt mobility device, with the tilt mechanism engaged, and positioned at an identified angle (degree). Resident #010 was unable to respond to questions asked by the inspector.

Registered Practical Nurse (RPN) #117 and Personal Support Worker (PSW) #101 indicated to Inspector #554, that resident #010 requires the tilt mobility device for positioning and comfort. RPN and PSW indicated that the tilt mobility device is considered a Personal Assistance Services Device (PASD) as resident is not able to get out of the mobility device him/herself, and that it is used to assist in maintaining resident’s position.

The clinical health record, for resident #010 was reviewed by the inspector. A physician's order (identified date), directs that a PASD is to be used for comfort and positioning.

The written plan of care (currently in place at the time of this inspection) did not identify that a PASD, and/or a tilt mobility devices as being part of the planned care for the resident.

Registered Practical Nurse #117, Documentation Nurse-RPN #118, as well as the Director of Care all indicated to the inspector, the written plan of care, should have included the tilt mobility device used as a PASD, as part of the planned care for resident #010. [s. 6. (1)]

2. The licensee failed to ensure that the written plan of care for residents #013 and #034, set out clear directions to staff and others who provide care to the residents, regarding responsive behaviours of an identified nature.

Related to Intake #015387-17:

The Executive Director submitted a Critical Incident Report (CIR) to the Director, on an identified date, regarding an incident of alleged resident to resident abuse which occurred four months earlier, where resident #034 was found to be in an identified area, exhibiting an identified responsive behaviour towards resident #013. Included in this same CIR were other incidents of alleged resident to resident responsive behaviours, which occurred over a four month period, and included resident #034 exhibiting responsive behaviours towards resident #013, and other residents on the unit.

Resident #034 was admitted to the long-term care home on an identified date, with history which includes cognitive impairment.

Inspector #672 reviewed the progress notes of resident #034, for the period of seven months. The progress notes documented ten incidents of observed responsive behaviours of an identified nature, involving resident #034.

Resident #013 was admitted to the long-term care home on an identified date, with history which includes cognitive impairment.

Inspector #672 reviewed the progress notes of resident #013, for the period of five months. The progress notes documented seventeen incidents of observed responsive behaviours of an identified nature, involving resident #013.

Inspector #672 reviewed resident #013’s written plan of care and noted that resident

#013 had a care plan focus regarding responsive behaviours. There were no goals or triggers in the written plan of care related to identified responsive behaviours, and the interventions stated that resident #013 was on an identified Responsive Behaviour Tracking Sheet (tool), and required increased monitoring for identified responsive behaviour, but did not state what “increased monitoring” entailed, nor any directions or interventions for staff to follow, if the resident was exhibiting the identified responsive behaviours.

Inspector #672 reviewed resident #034’s written plan of care, which directed staff that the resident was on safety checks, and to observe for inappropriate responsive behaviours, but did not provide clear directions or interventions for the staff to follow if those behaviours were observed. The written plan of care stated that the resident has heightened identified responsive behaviours, but did not address any resident to resident identified contact, nor direction or interventions for staff to follow if these behaviours were observed.

Inspector #672 interviewed Personal Support Worker (PSW) #122, who indicated that when these incidents were observed, the residents were separated, and the incidents were reported to registered nursing staff who were working on the unit. PSW #122 further indicated that resident #013 was not receiving increased nursing observation.

Inspector #672 interviewed PSW #126, who indicated that when incidents of responsive behaviour (of an identified nature), were observed, the incidents were reported to the registered nursing staff who were working on the unit, but that the residents were not always separated, due to this intervention possibly increasing the mood level (and or responsive behaviours) of either/both residents involved.

Inspector #672 interviewed Registered Nurse (RN) #119, who indicated that following each incident of observed resident to resident identified behaviours, the Director of Care (DOC) was informed initially, but this practice of reporting stopped, as he/she was informed by the DOC that the SDM of resident #013 consented to the relationship between resident #034 and resident #013, therefore it was believed to be acceptable for these incidents to occur. RN #119 further indicated that there were times when the residents would not be separated following an incident of observed responsive behaviour, as one or both residents would sometimes exhibit an identified responsive behaviour if staff attempted to redirect or separate the residents involved.

Inspector #672 interviewed the Director of Care (DOC), regarding the alleged incidents of

resident to resident responsive behaviours. The DOC indicated that he/she had been aware of the incident between resident #013 and #034 on an identified date, and was aware of 'periodic episodes of resident to resident responsive behaviours by both resident #013 and #034.

The licensee has failed to ensure that the written plan of care for resident #013 set out clear directions to staff, regarding the exhibited responsive behaviours of an identified nature, as there were no directions for staff to follow in regards to how often resident #013 was to be observed, despite being on "increased monitoring'; there were no clear directions for staff on how to react, intervene, or follow up with the resident, if necessary, if responsive behaviours of an identified nature were observed; and there were no instructions for staff, to follow, to ensure consent and capacity to consent were assessed following each incident of a responsive behaviour of an identified nature were observed.

The licensee failed to ensure that there were clear directions provided for staff regarding resident #034, related to responsive behaviours of an identified nature, specifically related to not providing directions or instructions for staff to follow if resident #034 was observed to be exhibiting a responsive behaviour of an identified nature, how staff were to react, intervene, or follow up with the resident, if necessary; and there were no instructions for staff to ensure consent and capacity to consent were assessed following each incident of an observed responsive behaviour of an identified nature. [s. 6. (1) (c)]

3. The licensee failed to ensure that the plan of care, for the resident, was revised when the care set out in the plan had not been effective, and that different approaches had been considered.

Related to Intake #035404-16:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director, on identified date, for an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status. Resident #037 had an incident four days earlier, and sustained injury.

Resident #037 history, includes, cognitive impairment.

The clinical health record, for resident #037, was reviewed, by Inspector #554, documentation is as follows:

Written Care Plan (identified date):
- A review of the written plan of care, indicated that resident #037 had several interventions in place related to mobility, transfers, toileting, and falls.

Progress Notes:
- On an identified date – Personal Support Workers (PSW) were providing care to resident in an identified area. Resident left the identified area to obtain his/her mobility aid, upon re-entering the area, resident slipped and fell to the floor. Assessed by registered nursing staff to have no injury. Referral to physiotherapy.
- Approximately twenty days later – PSW reported that resident fell while in an identified area. Staff reported being present when resident fell. Assessed by registered nursing staff to have no injury. Referral to physiotherapy.
- Three days later (from above date) – Resident was walking in an identified area, lost balance and fell. Fall was witnessed by PSW. Assessed by registered nursing staff to have no injury. Head Injury Routine initiated. Referral to physiotherapy.
- Ten days later (from above date) – Resident was walking in an identified area with his/her mobility aid, when he/she fell backwards onto the floor. Assessed by registered nursing staff to have no injury. Head Injury Routine initiated. Referral to physiotherapy.
- Two days later (from above date) – Staff heard resident #037 shouting while in an identified area; staff found resident lying on the floor. Assessed by registered nursing staff to have no injury. Head Injury Routine initiated. Referral to physiotherapy.
- Two days later (from above date) – Staff reported hearing a loud noise, upon assessment of the noise, staff found resident lying on the floor. Assessed by registered nursing staff to have no injury. Head Injury Routine initiated. Referral to physiotherapy.
- Nineteen days later (from above date) – Resident was walking in an identified area, when he/she lost balance and fell. Assessed by registered nursing staff to have no injury. Head Injury Routine initiated. Referral to physiotherapy.

On an identified date (one day from last identified fall), resident complained of discomfort to an identified area, and later complained of discomfort elsewhere. Registered Nursing Staff documented resident was screaming saying he/she was in discomfort; resident complained of discomfort to identified areas. Resident was administered an analgesic, but needed assistance from staff to drink and take the medication. Resident was seen by a physician, at the long-term care home, later that day, with orders written for diagnostic testing to be done. Three days later, diagnostic tests taken confirmed a specific diagnosis. Resident was assessed at an identified clinic, and returned to the long-term care home with identified treatment measures in place. Resident was provided a temporary mobility device, as he/she was unable to ambulate using his/her mobility aid,

due to an identified area being immobilized.

The Director of Care, as well as the Regional Manager of Education Services, who is a corporate representative (of the licensee) for the long-term care home, indicated it is the expectation that the plan of care is to be at all times reflective of the care required for the resident. Both indicated, to Inspector #554, that if the plan of care is not effective, that registered nursing staff are to review, revise and consider different interventions in caring for the resident.

Registered Nurse (RN) #119, who works on the resident home area where resident resides, indicated to Inspector #554, that resident #037 is at risk for falls.

RN #119, as well as the Physiotherapist (PT) reviewed the plan of care for resident #037, with Inspector #554, and indicated that the plan had not been revised or different approaches considered, noting that resident fell seven times in a three month period.

Upon further review of the clinical health record, for this resident, documentation indicates that resident #010 continues to have falls incidents, with five additional falls occurring during a three month period, after the identified diagnosis (mentioned above).

The plan of care for resident #037, specific to the identified falls risk, and interventions to reduce falls and mitigate risk of injury, was not revised and or different approaches considered during a seven month period; resident has had twelve falls during the identified period. [s. 6. (11) (b)]

4. Related to Intake #008653-17:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director, on an identified date, for an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status. Resident #031 fell and sustained injury.

Resident #031 was admitted to the long-term care home on an identified date. Resident's history includes, cognitive, physical and visual impairment. Resident's substitute decision maker (SDM) indicated to registered nursing staff on admission, as documented in a progress note on an identified date, that resident #031 has a history of falls.

Physiotherapist assessed resident, four days later, and identified that resident was at

high risk for falls.

The clinical health record, for resident #031, including the written care plan, progress notes, post-fall assessments, physiotherapy referrals, and physiotherapy assessments, were reviewed, by Inspector #554, for the period of one and a half months, documentation is as follows:

Admission Assessment and Care Plan (identified date):
- Resident #031 has cognitive and visual impairment, walks with a mobility aid and has a history of falls.

Written Care Plan (identified date) - identified several interventions related to transfers and mobility.

There is no fall prevention and management focus for this resident in the written care plan.

Progress Notes:
- On Admission (identified date) - Registered Practical Nurse #100 documented, in an admission progress note, that resident walks with a mobility aid and is at risk for falls.
- Four days later – Physiotherapist's initial assessment, details that resident has a history of cognitive impairment, walks with a mobility aid and is at high risk for falls.
- Twenty-three days later (from admission) – Unwitnessed fall; resident was found on floor between bed and chair. Resident was assessed by registered nursing staff, and found to have sustained injuries. On the same date, approximately twelve hours later, resident was found on the floor in an identified area. Resident was assessed by registered nursing staff, and was assessed as unable to weight bear. Resident was transferred to hospital for assessment and returned to the long-term care home later that same date. Documentation in the progress notes, indicated no new injury found.
- Three days later – Post fall monitoring documentation notes that resident #031 is unable to weight bear, and is unable to get self into a sitting position without assistance from staff. Reminded to call for assistance. Analgesic provided.
- Nineteen days later – Staff indicated that resident was ambulating without his/her assistive aid, and fell while returning to his/her chair. Assessed by registered nursing staff to have no injury. Later that same date, staff documented that resident was found walking without his/her mobility aid.
- The next day – Staff reported, resident #031 was trying to get up from his/her bed. Later, same date, staff reported, that resident was returning from an identified area,

ambulating with his/her mobility aid, became weak, and before staff could reach resident, he/she fell to the floor. Resident was assessed, by registered nursing staff, to have no injury.
- The next day – Resident was found on the floor. Assessed, by registered nursing staff, to have no injuries. Placed on head injury monitoring.

The Director of Care, as well as the Regional Manager of Education Services, who is a corporate representative (of the licensee) for the long-term care home, indicated it is the expectation that the plan of care is to be at all times reflective of the care required for the resident. Both indicated, to Inspector #554, that if the plan of care is not effective, that registered nursing staff are to review, revise and consider different interventions.

Registered Practical Nurses (RPN) #115, who works on the resident home area where resident resides, and Documentation Nurse-RPN #118 indicated, to Inspector #554, that resident #031 was at risk for falls and that interventions should be in place to reduce falls and or to prevent potential injury.

RPN #115 and #118, as well as the Physiotherapist (PT) reviewed the plan of care for resident #031, with Inspector #554, and indicated that the plan of care, for resident #031, had not been revised nor had different approaches been considered for the resident, noting resident fell four times in a twenty-two day period.

The plan of care for resident #031, specific to the identified falls risk, and interventions to reduce falls and mitigate risk of injury, was not revised and or different approaches considered until an identified date, following resident #031's fifth fall. [s. 6. (11) (b)]

5. Related to Intake #011758-17:

A Critical Incident Report (CIR) was submitted to the Director on an identified date, related to a fall incident that occurred a day earlier and resulted in injury. The CIR indicated that resident #038 had an un-witnessed fall in the hallway, of the resident home area. Resident was transferred to the hospital, had diagnostic testing performed, which identified a specific injury.

Review of resident #038's health records by Inspector #461, indicated that resident has a history which includes cognitive and physical impairment. Progress notes and post-fall assessments for a six month period, indicated the following:

- The resident #038 sustained thirty (30) falls during an identified six month period.
- A progress note (identified date), indicated that resident's POA/SDM (Power Of Attorney/Substitute Decision Maker) requested that the long-term care home to take steps to have a fall's prevention device for resident. The fall prevention device was added to the plan of care on an identified date, after fourteen falls have already occurred.

- The MDS-RAI assessment for an identified date, was completed for a significant change in status, indicating that resident's level of assistance for activities of daily living, specifically bed mobility, transfer, walk in room, and toileting changed.

Review of the current plan of care for resident #038 in the electronic health record identified that there were several fall prevention interventions in place.

During observations of resident #038, by Inspector #461, resident was noted to be walking unsteady in an identified area, holding onto the tables and other residents for support without using his/her mobility aid, on both dates PSW #121 and #125 approached resident with the mobility aid and walked with resident to his/her room. On an identified date resident also required two staff assistance for transfers, due to unsteady gait and resistive behaviour.

During interviews with PSW #122 and #125, by Inspector #461 indicated that resident is at high risk of falls due to unsteady gait and attempting to walk without mobility aid and self-transferring. PSWs #122 and #125 indicated that resident was encouraged to use the mobility aid, resident often refuses to use mobility aid due to cognitive impairment. Both PSWs indicated that resident needed to be followed and assisted even when he/she was walking with the mobility aid. RPN #118 and RN #119 indicated that the expectation was to review and revise resident's care plan after each fall; both registered staff indicated this review and revision, of the care plan, was not consistently completed for resident #038.

The plan of care for resident #038 was not reviewed and revised when interventions were no longer effective and when resident's care needs changed post-fall incidents, as supported by the following:

During interviews, the DOC and Regional Manager of Educational Services (RMES) indicated that a multidisciplinary team meeting was held on an identified date, post submission of CIR (identified date), where it was identified that resident's interventions were not revised after each fall, that there was no plan to manage resident's unsteady

gait given a specific diagnosis admission, and there was no plan to determine the cause of resident’s falls.

Regional Manager of Educational Services (RMES) indicated that the plan of care was not revised when the care set out in the plan had not been effective, and that different approaches had not been considered, specifically reassessment of the root cause of resident's falls and possible linkage to medical diagnosis. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that the written plan of care for each resident that sets out, the planned care for the resident; clear directions to staff and others who provide direct care to the resident; and that the plan of care, for a resident is revised when the care set out in the plan has not been effective, and that different approaches are considered, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Under, LTCHA, 2007, s. 8 (1) - Every licensee of a long-term care home shall ensure that there is, (a) an organized program of nursing services for the home to meet the assessed needs of the residents; and (b) an organized program of personal support services for the home to meet the assessed needs of the residents.

Under, O. Reg. 79/10, s. 30 (1) - Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Under, O. Reg 79/10, s. 48 (1) - Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home, specifically, a falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee policy, “Fall Prevention and Injury Reduction Program” communicates that the licensee is committed to providing a Fall Prevention and Injury Reduction Program to reduce the incidence of falls and risk of injury.

This policy, Fall Prevention and Injury Reduction Program, directs that interdisciplinary team will use identified tools to identify and assess residents for fall related risk, and following falls that occur, specific tools will be utilized to identify resident falls risk, one tool that identified as being in use by the licensee in this policy, is the “Falling Star Logo Labels”.

A second licensee policy, “LTC-Fall Prevention”, which is included in the Falls Prevention and Injury Reduction Program, directs that all residents identified as being at immediate risk for falls are identified with a falling star logo. The policy states that the “Falling Star Logo” is placed on the resident’s health record (chart spine), bedside, a nameplate in the hall, assistive device, or where applicable to effectively communicate the resident’s fall risk.

The Documentation Nurse-RPN #118, and the Regional Manager of Education Services (RMES), indicated to Inspector #554, that residents assessed as being at moderate or high risk for falls will be identified using a falling star logo. RPN #118 indicated that the

falling star logo is placed on the spine of the resident's health record, and on the nameplate outside the identified resident's door. The Regional Manager of Education Services indicated, to the inspector, that falling star logo is to be placed in designated locations (resident's health record (chart spine), bedside, on the nameplate in the hall, and ideally on the resident's assistive device for residents' identified at being at moderate to high risk.

Related to Intake #008653-17:

Resident #031 has a history which includes cognitive, physical and visual impairment.

On admission resident was identified as having a pre-existing fall history, as per the pre-admission information package (identified date) and as communicated by resident's substitute decision maker (SDM) and family, in a progress note, written by registered nursing staff, on admission date.

A FRAT (fall risk assessment tool) completed on an identified date, by registered nursing staff, identifies that resident was assessed to be a 'high' risk for falls. A FRAT, completed (later date), identifies that resident remains at high risk for falls.

The written plan of care (identified date) identifies several fall prevention interventions.

Inspector #554 did not observe a "Falling Star Logo" on resident #031's health record (chart spine), bedside, a nameplate in the hall, or on his/her assistive device.

Registered Practical Nurse (RPN) #117, and Documentation Nurse-RPN #118 indicated, to Inspector #554, that resident #031 remains at high risk for falls. RPN #117 and #118 indicated that the falling star logo, used to identify resident as being at high falls risk, was not present in the identified areas as per the licensee's policy, Falls Prevention and Injury Reduction, for resident #031. [s. 8. (1) (a),s. 8. (1) (b)]

2. Related to Intake #035404-16:

Resident #037 has a medical diagnosis which includes cognitive impairment.

A FRAT (fall risk assessment tool) completed on an identified date, by registered nursing staff, has identified that resident was assessed to be a 'high' risk for falls. A FRAT was completed six months later, and identifies that resident remains at high risk for falls.

The written plan of care (identified date) identifies the following:
- Resident #037 has been assessed as high risk for falls, as evidence by multiple falls, poor judgement, impaired cognition and responsive behaviours.

Inspector #554 did not observe a “Falling Star Logo” on resident #037’s health record (chart spine), bedside, a nameplate in the hall, or on his/her assistive device.

Documentation Nurse-RPN #118 indicated, to Inspector #554, that the falling star logo should be found on the health record (chart spine) and on the nameplate outside of the door to the resident’s room, for all resident's assessed to be at moderate to high fall risk.

Registered Nurse (RN) #119 indicated, to inspector, that resident #037 is at high risk for falls. RN indicated, to the inspector, that the falling star logo is not currently in use for this resident despite the identified risk being assessed as high. RN indicated it was his/her belief that the falling star logo is no longer used to identify residents at moderate to high risk for falls. RN #119 indicated that this was a directive from nursing management.

The Director of Care indicated, to the inspector, that the long-term care home is currently not using the falling star logo, to identify falls risk, although the policy, "Fall Prevention and Injury Reduction Program”, which speaks to use of the falling star logo, is currently in effect. DOC indicated that the falling star logo's were removed (his/her direction to staff); DOC indicated, that it was his/her belief, that the initial direction for the logo removal, came from the licensee, and that the rationale for removal (of the falling star logo) was that the licensee's was in the process of changing it's Fall Prevention and Injury Reduction Program.

The Executive Director indicated, to the inspector, that he/she herself did not receive any written or verbal communications or direction from licensee to remove the 'falling star logo's'.

The Regional Manager of Education Services, who is a Corporate representative (of the licensee), indicated, to the inspector, that the Falls Prevention and Injury Reduction Program is corporately driven, and that the expectation is that the policies will be followed within the long-term care homes. The Regional Manager of Education Services, indicated that the falling star logo is in effect and should currently be in place for those residents identified as being at moderate or high risk for falls; Regional Manager of Education Services indicated that there was no directive from the licensee to remove the

falling star logo's, as a means of identification of falls risk.

The licensee failed to ensure that the falling star logo, as part of the Fall Prevention and Injury Reduction Program, was in place to identify residents #031, and 037 as being at high risk for falls, as directed by the licensee's policy.

3. Related to Intake #011758-17:

Review of resident #038’s health records by inspector #461, indicated that resident has a history which includes cognitive and physical impairment. Progress notes and post-fall assessments for a six month period, indicated that resident sustained thirty falls during that time. On an identified date, resident had a fall that resulted in an identified injury.

Review of the current plan of care for resident #038 indicated the resident is at high risk for falls related to impaired cognition (non-compliant with the use of mobility aid), and occasional gait imbalance.

Observations of resident #038 on identified dates, by Inspector #461 indicated the Falling Star Logo was not in place in the resident’s room, on resident's mobility aid/devices or nameplate in the hall, or the resident’s chart.

During interviews with PSWs #122 and #125, RN #119, they all indicated that resident was at high risk of falls. PSW #122 reported the long-term care home used to have Falling Star logos to identify residents at high risk of falls, but PSW has not seen the logo on resident’s room or mobility aid since starting working in the identified resident home area, about a month ago. The RN #119 indicated that he/she has not seen the falling star logo for resident #038.

During an interview, with the DOC indicated to Inspector #461 the expectation is that any resident identified at moderate or high risk of falls should have a Falling star logo posted. The DOC confirmed that the "Falling Star logos" have not been used in the long-term care home for over a month. DOC indicated that the falling star logo's were removed, as per direction of the licensee, as the licensee's is in the process of changing it's Fall Prevention and Injury Reduction Program; the DOC indicated that the Falls Prevention and Injury Reduction Program policies remain in place, which includes reference to use of the falling star logo.

The licensee did not place the "Falling Star Logo" on resident #038’s assistive

aid/devices, bedside, nameplate in the hall, or chart as per licensee's Fall Prevention and Injury Reduction Policy.

Prior to inspectors exiting the long-term care home, the "falling star logo's" were visible within the long-term care home identifying residents at moderate to high risk for falls. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: 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 :

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

Under O. Reg. 79/10, s.2 (1) (c) "physical abuse" means, the use of physical force by a resident that causes physical injury to another resident.

The licensee's policy "Resident Non-Abuse" reviewed, by Inspector #672, indicated under procedure:
- Anyone who becomes aware of or suspects abuse or neglect of a resident must immediately report that information to the Executive Director, or if unavailable, to the

most senior supervisor on shift.

Related to residents #036 and #039:

The progress notes, specific to resident #036 were reviewed by Inspector #570 for the period of approximately two months. Progress notes reviewed, provided details of the following:

- On an identified date, RPN #124 documented that resident #036 exhibited an identified responsive behaviour towards resident #039 while in an identified area of the long-term care home. Resident #036 was moved to another area.

Review of progress notes, specific to resident #039 provided details of the following:
- On an identified date, RPN #124 documented that resident #036 exhibited an identified responsive behaviour towards resident #039; injury was identified.

There is no indication that Registered Practical Nurse #124 reported the above incident to the Registered Nurse-Charge Nurse on the date of the incident.

During interviews with the DOC and the Executive Director, both indicated to the inspector, no awareness of the above incident. The DOC and the Executive Director further indicated that the alleged resident to resident abuse involving resident #039 by resident #036 was not reported to the Director.

The licensee failed to ensure that the written policy which promotes zero tolerance of abuse and neglect of residents was complied with, as supported by the Director of Care, and the Executive Director indicated that RPN #124 did not report the resident to resident abuse incident involving residents #36 and #39 to the Executive Director, and/or if unavailable, to the most senior supervisor. (570) [s. 20. (1)]

2. Under O. Reg. 79/10, s.2 (1) (c) "physical abuse" means, the use of physical force by a resident that causes physical injury to another resident.

Review of the licensee’s policy “Resident Non-Abuse” indicated under procedure:
-Anyone who becomes aware of or suspects abuse or neglect of a Resident must immediately report that information to the Executive Director, or if unavailable, to the most senior supervisor on shift.

Related to Intake #034435-16:

The progress notes, specific to residents #035 and #036, were reviewed by Inspector #570, for the period of approximately two months. Progress notes reviewed, provided details of the following:

- On an identified date, RPN #124 documented that resident #035 exhibited an identified responsive behaviour towards resident #036 without any reason. Resident #035 was assessed and was noted to have injuries to an identified area.

There is no indication that Registered Practical Nurse #124 reported the above incident to the Registered Nurse-Charge Nurse, on the identified date.

Review of incident report in the electronic health record on an identified date, and documented by RPN #124. The RPN documented in the report, the injuries sustained to resident #035.

During interviews with the DOC and the Executive Director, both indicated to the inspector, no awareness of the above incident. The DOC and the Executive Director further indicated that the alleged resident to resident abuse involving resident #035 by resident #036 was not reported to the Director, and or to themselves and or to the RN-Charge Nurse, assigned on the identified date.

The licensee failed to ensure that the written policy which promotes zero tolerance of abuse and neglect of residents was complied with, as supported by the Director of Care, and the Executive Director indicated that RPN #124 did not report the resident to resident abuse incident involving residents #35 and #36 to the Executive Director, and/or if unavailable, to the most senior supervisor. (570) [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

The licensee failed to ensure that the admission care plan must identify the resident and must include, at a minimum, the following with respect to the resident, any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.

Under O. Reg. 79/10, s. 24 (1) - Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident’s admission to the home.

Related to Intake #008653-17:

Resident #031 was admitted to the long-term care home on an identified date. Resident has a history which includes cognitive, physical and visual impairments.

The pre-admission documentation (identified date) indicated that resident #031 had a history of falls. As per the pre-admission documentation, resident #031’s most recent fall occurred three weeks prior to his/her admission to the long-term care home.

The clinical health record, for resident #031, was reviewed, by Inspector #554, for the period of one month, documentation is as follows:

- Admission Date (identified date) – Admission Assessment and Care Plan – indicated that resident is cognitively impaired, has a visual impairment, walks utilizing a mobility aide and has a history of falls.
- Same Date - Registered Practical Nurse #100 documented, in an admission progress note, that resident walks with a mobility aide and is at risk for falls.
- Three days later – Physiotherapist indicated in his/her initial assessment that resident walks with a mobility aide and is at high risk for falls.
- Twenty-Six days from admission (approximately) – Resident #031 had an unwitnessed fall, and was found on floor; sustained injuries to identified areas. Twelve hours later, resident was found on the floor (another fall), resident was unable to weight bear, following the fall and was transferred to hospital for assessment and treatment.

The Admission Assessment and Care Plan (identified date), as well as the written care plan (identified date) reviewed, by the inspector, failed to provide documentation as to resident #031's identified falls risk and or interventions in place to mitigate risk.

Registered Practical Nurse/Documentation Nurse #118 indicated, to Inspector #554, that the Admission Assessment and Care Plan, which is the care plan for the newly admitted resident, is to be a reflection of care required by the resident, and should have identified risk for falls and related interventions. RPN #118 further indicated, that the written care plan (identified date) should have further identified that resident #031 was at risk for falls, and should have identified interventions in place at that time to prevent falls and or injury to the resident.

Director of Care, as well as the Regional Manager of Education Services, indicated to Inspector #554, that the risk for falls, for resident #031, and interventions to mitigate risk should have been identified in both documents, the Admission Assessment and Care Plan (identified date), as well as the written care plan (identified date). [s. 24. (2) 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 there is a process in place and monitored ensuring hat the admission care plan must identify the resident and must include, at a minimum, the following with respect to the resident, any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Under O. Reg. 79/10, s. 2 (1) (c) "physical abuse" means, the use of physical force by a resident that causes physical injury to another resident.

Under O. Reg. s. 2 (1) (b) “sexual abuse” means, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Related to Intake #034435-16:

The Executive Director submitted a Critical Incident Report (CIR) to the Director, on an identified date, regarding an alleged incident of resident to resident abuse, which was said to have occurred six days earlier.

The CIR indicated that resident #035 grabbed an item on resident #036's mobility aide and resident #036 began to exhibit an identified behaviour towards resident #035. Staff separated the two residents. No injury noted at time of incident. An injury was noted to resident #035 during physician assessment.

Review of incident report in electronic health record (on identified date) by RN #123 indicated that identified injuries, for resident #035, were observed at time of incident.

Review of progress notes for resident #035 indicated, three separate entries (identified dates) where an RN, Physiotherapist and the Physician assessed resident and identified injuries.

The Executive Director indicated (on an identified date) that since an injury was noted and documented in the progress notes, the incident should have been immediately reported to the Director. [s. 24. (1)]

2. Related to Intake #015387-17:

A Critical Incident Report (CIR) was submitted to the Director on an identified date, regarding an alleged incident of resident to resident abuse, which occurred four months earlier, between resident #034 and resident #013.

Inspector #672 interviewed PSW #122; PSW indicated that when the incident was observed, the residents were separated, and the incident was immediately reported to registered nursing staff on the unit.

Inspector #672 interviewed RN #119; RN indicated that when the incident between resident #034 and resident #013 occurred, the DOC was immediately informed of this

incident.

Inspector #672 interviewed the DOC; the DOC indicated that he/she had been immediately informed of the incident (identified date) between resident #013 and #034, by registered nursing staff. When Inspector #672 inquired as to why the incident had not been submitted to the Director, the DOC indicated that at that time, he/she had not believed the incident met the criteria for submission to the Director, as he/she had not felt that the incident met the definition of resident to resident abuse.

Inspector #672 interviewed the DOC again (identified date), along with Inspector #570, where the definition of resident to resident abuse was reviewed, and the DOC indicated that the incident between resident #034 and resident #013 met the definition of resident to resident sexual abuse, therefore the incident should have been submitted to the Director.

The licensee has failed to ensure that when there was reasonable grounds to suspect that abuse of resident #013 by resident #034 had occurred, the suspicion and the information upon which it was based was immediately reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that a person who had reasonable grounds to suspect that, abuse of a resident by anyone, had occurred or may occur, immediately report the suspicion and information upon which it was based to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items.

During the initial tour of home, on July 04, 2017, the following was observed by Inspector #570:

- The Spa room in an identified resident home area, was observed to have an unlabelled bottle of body lotion, and two bottles of deodorant left on the counter-top vanity. All items were used;
- The Shower room (identified resident home area) was observed to have an unlabelled bottle of shampoo left on the counter-top vanity;
- The Spa room (identified resident home area) was observed to have an unlabelled and used nail clipper, an unlabelled and used comb, both items were left on the counter-top vanity;
- The Shower room (identified resident home area) was observed to have unlabelled hair brush, a comb and two tooth brushes; all items were used and left on counter-top vanity;
- The Shower room (identified resident home area) was observed to have unlabelled body lotion, a bottle of baby powder, two hair brushes, and a deodorant, all items were used and located in the vanity cupboard above sink.

All of the above identified rooms are considered communal resident areas.

During an interview with RPN #100, RPN indicated that the identified deodorants and any other residents` personal care items should be labelled and stored in the residents’ cupboard. The RPN could not identify to who the deodorants found in the identified spa room belong.

During an interview with the DOC, the DOC indicated to Inspector #554 that all resident personal care items are to be labelled for individual resident use and stored appropriately in the residents` cupboard. The DOC indicated that staff have access to a labeller and permanent markers to use to label residents' personal care items.

During subsequent observations (on identified dates), Inspector #554 observed the following:

- Resident Room (identified room) – the washroom within the resident room was observed to have a brush, comb, toothbrush, two denture cups, and a soap dish containing three bars of soap; all items were observed on the counter-top vanity and not labelled for individual use. This is a shared resident room. Neither residents within the room could tell the inspector who’s the personal care items belonged to, as both residents have a history of cognitive impairment. Both residents are provided personal care by staff.
- Resident Room (identified room) – the washroom within the resident room was observed to have two toothbrushes, two k-basins, two hairbrushes (both containing hair in the bristles), and two combs; all items were observed on the counter-top vanity and not labelled for individual use. This is a shared resident room. Neither residents within the room could tell the inspector who’s the personal care items belonged to, as both residents have a history of cognitive impairment. Both residents are provided personal care by staff.

The Director of Care (DOC) indicated to Inspector #554, that all personal care items are to be labelled for each resident and stored in individual storage shelving units in the resident washroom; indicating further that personal care items are not to be left on counter-top vanities, especially in a shared resident washroom. DOC indicated that if personal items were left unlabelled on counter-top vanities nursing staff would be unable to safely determine which care items belonged to which resident, thus needing to be disposed of. DOC indicated that the practice is, that all personal care items are labelled on admission and then as needed by nursing staff. DOC indicated that each resident home area is equipped with a labeller and nursing staff are given markers as well for labelling of resident personal items.

Personal Support Worker (PSW) #101, and Registered Practical Nurses #115 and #117 indicated to Inspector #554 that resident personal items, e.g. toothbrushes, and combs are labelled upon admission. PSW #101 and RPN’s #115 and #117 indicated that they are not aware of any process or procedure in place for relabeling of personal items

following admission. (554) [s. 37. (1) (a)]

2. The licensee's admission checklist, entitled "PSW/HCA Resident Admission Checklist for First 24 hours" directs that, personal care items (including toothbrush, comb, electric razor as required, ect.) are to be labelled. The admission checklist further directs that dentures, denture cup, glasses and hearing aids are to be labelled, within 24 hours of admission.

Resident #031 was admitted to the long-term care home on an identified date. Resident has a history which includes cognitive, physical and visual impairment. Resident relies on staff for assistance with activities of daily living.

The clinical health record for resident #031 was reviewed, by Inspector #554, with the following documented by registered nursing staff:

- On admission (identified date), resident's substitute decision maker (SDM), and family, indicated that resident has upper and lower dentures. SDM indicated that resident will often place his/her lower dentures in his/her pocket.
- Over a month later (identified date) – SDM telephoned registered nursing staff to communicate that resident #031 had the wrong dentures in his/her mouth, as reported to him/her (SDM) by another family member.

Personal Support Worker (PSW) #101, who works on resident #031's resident home area, indicated, to Inspector #554, that resident dentures are not labelled by PSWs, and that he/she is not aware if resident #031's dentures are labelled or not.

Registered Practical Nurses (RPN) #115 and #117, who are not newly employed staff, and are both assigned to resident home area where resident #031 resides, indicated, to Inspector #554, that resident #031 does have dentures. RPN #115 and #117 indicated that the long-term care home does not label personal aids such as dentures and or hearing aids.

Registered Practical Nurse #117 assisted resident #031 to his/her room, assisted resident with mouth care, and indicated to Inspector #554, that resident #031's upper and or lower denture were not labelled.

Director of Care indicated, to Inspector #554, that personal items, including dentures and hearing aids are to be labelled upon admission, and that it is up to the registered nursing

staff and personal support workers to ensure such is completed.

Prior to inspectors exiting the long-term care home (identified date), Inspector #554 observed a registered staff member circulating 'denture labelling kits' and markers to resident home areas for labelling of personal items, including dentures. [s. 37. (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 there is a process in place and monitored, ensuring that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the resident's responses to the interventions were documented.

Related to Intake #015387-17:

A Critical Incident Report (CIR) was submitted to the Director on an identified date, regarding an incident of alleged resident to resident abuse, which occurred approximately four months earlier, where resident #034 was found in an identified area with resident #013, exhibiting an identified responsive behaviour towards resident #013. The CIR also included information regarding other incidents of alleged resident to resident abuse, involving residents #013, #034, #042, and #044, which occurred during a four month period of time.

Resident #034 was admitted to the long-term care home on an identified date, with history which includes cognitive impairment.

Review of resident #034's progress notes, for a period of seven months, identified that resident #034 had been involved in nine incidents of exhibited resident to resident responsive behaviours of an identified nature during that time period.

Resident #013 was admitted to the long-term care home on an identified date, with a history which includes cognitive impairment.

Review of resident #013's progress notes, for a period of approximately five months, identified that resident #013 had been involved in eighteen incidents of exhibited resident to resident responsive behaviours of an identified nature during that time period.

Inspector #672 interviewed PSW #126, who indicated that when these incidents were observed, the incidents were reported to the registered nursing staff on the unit, but the residents were not always separated, due to this possibly increasing the mood level (exhibiting an responsive behaviour) of either/both residents involved.

Inspector #672 interviewed RN #119, who indicated that following each observed incident of exhibited responsive behaviours of an identified nature by resident #034 and/or resident #013, the Director of Care (DOC) was initially informed, but this practice stopped once RN #119 states he/she was informed by the DOC that the SDM of resident #013 consented to the relationship between resident #034 and resident #013, therefore it was then considered acceptable for these incidents to occur. RN #119 further indicated that there were times when the residents would not be separated following an incident of observed responsive behaviours of an identified nature, as one or both residents would

sometimes exhibit an identified responsive behaviour if staff attempted to redirect or separate the residents involved.

Inspector #672 reviewed resident #013's written plan of care (identified date), which stated that resident #013 exhibits identified responsive behaviours. The interventions stated that resident #013 was on an identified responsive behaviour tracking tool, and required increased monitoring for identified responsive behaviours, but the written plan of care did not state what 'increased monitoring´ entailed, nor any interventions or directions for the staff to follow, if the resident was observed to be exhibiting responsive behaviours, of an identified nature.

Inspector #672 reviewed resident #034's written plan of care, which informed staff that the resident was on safety checks, and required observation for inappropriate responsive behaviours. The written plan of care did not provide direction for the staff to follow, if those behaviours were observed. Review of the most recent written plan of care (identified date) for resident #034, stated that the resident has heightened (identified) responsive behaviours, but did not reflect any resident to resident identified contact, or interventions for staff to implement, if these exhibited responsive behaviours were witnessed.

Inspector #672 interviewed the DOC regarding the incidents of observed responsive behaviours of an identified nature, between residents #013, #034, #042, #044. The DOC indicated having awareness of the incidents between resident #013 and resident #034 which occurred on an identified date, and was aware of 'periodic episodes of responsive behaviours of an identified nature by both resident #013 and resident #034. The DOC further indicated that although both residents had been on an identified responsive behaviour tracking (tool) at times, once those assessments were completed, there was not a process in place for the information to be reviewed and/or acted upon, indicating that the sheets were filed in the resident's chart, for review by the physician, only in the event they were considering medication changes.

Resident #034 and #013 were not reassessed, and additional strategies and interventions were not implemented following the ongoing responsive behaviours of an identified nature. (672) [s. 53. (4) (c)]

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 there is a process in place and monitored, ensuring that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the resident’s responses to the interventions were documented, to be implemented voluntarily.

WN #8: 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).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

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

The licensee's policy, Hand Hygiene directs that, all employees will:
- Use only alcohol based hand rubs with alcohol concentration of 70% or greater.
- Use alcohol-based hand rub as the preferred method of hand hygiene when hands are not visibly soiled.
- Perform hand hygiene at the point of care.
- Avoid touching contaminated surfaces or objects after performing hand hygiene.
- All employees will perform hand hygiene before, between and after activities that may result in cross-contamination (your Moments of Hand Hygiene).

On an identified date, Inspector #672 observed the nourishment cart being circulated on an identified resident home area. Personal Support Worker (PSW) #105 was observed to be completing the nourishment pass. Inspector #672 observed PSW #105 completing tasks such as handling the snack items with his/her bare hands, assisting residents with their nourishment, assisting a resident into the dining room by pushing a wheelchair to the table, touching a resident on the shoulder while speaking with them, and removing dirty glasses from a resident room. No hand hygiene was observed being performed by PSW #105, between handling the food items, assisting residents with the nourishment, and/or the other tasks observed.

Inspector #672 interviewed PSW #105, the PSW indicated that he/she usually completes hand hygiene from the sanitization stations available in the resident hallways. PSW #105 acknowledged that he/she had forgotten to complete hand hygiene during the nourishment pass on the identified date.

During subsequent observations (another date), Inspector #672 observed the nourishment cart being circulated, on an identified resident home area, being completed by PSW #106. Inspector #672 observed PSW #106 assisting several residents with their nourishment, assisting a resident to mobilize up the hallway in their wheelchair, and assisting another resident into a chair in the dining room, but did not observe PSW #106 performing hand sanitization during the nourishment pass.

On an identified date, Inspector #672 observed part of the nourishment cart being circulated on another resident home area, completed by PSW #108. While completing the nourishment pass, PSW #108 was observed to be assisting several residents with personal tasks, such as straightening the pants of a resident, removing dirty dishes from a resident room, and handing a television remote to a resident. Inspector #672 interviewed PSW #108 following the nourishment pass; PSW #108 indicated to Inspector #672 that he/she completes hand hygiene at the beginning of the nourishment pass, and then again at the end of the nourishment pass, but that he/she does not complete hand hygiene during the nourishment pass.

Inspector #672 interviewed the Director of Care (DOC), in regards to the expectation of hand hygiene during the nourishment passes. The DOC indicated to Inspector #672 that the expectation is that hand hygiene is completed between assisting each resident, and/or if the PSW touches any other surface, such as a bannister in the hallway, the handles of a wheelchair, or assisting a resident into a seat. The DOC indicated that PSW #105, PSW #106, and PSW #108 did not follow the licensee's policy regarding infection

control, and proper hand hygiene. [s. 229. (4)]

2. The licensee has failed to ensure that the hand hygiene program is in accordance with evidence based practices and, if there are none, in accordance with prevailing practices, and with access to point of care hand hygiene agents.

During the dates of this inspection, alcohol based hand rub (ABHR) dispensers, at the point of care, were not observed in all private resident’s rooms on all four resident home areas. Point of Care ABHR dispensers, were observed in semi-private rooms on two identified resident home areas.

The Director of Care (DOC), in an interview, indicated he/she is lead of the long-term care home's (LTCH) Infection Prevention and Control Program. The DOC indicated that for infection control practices including hand hygiene, the LTCH follows guidelines mandated by the public health and best practice guidelines by PIDAC (Provincial Infectious Disease Advisory Committee).

The licensee's policy, Infection Prevention and Control Program acknowledges that the long-term care home's IPC program will be monitored and evaluated for compliance with local health authority guidelines and standards set by any governing body.

The licensee’s Hand Hygiene policy directs that, all employees will:
- Use only alcohol based hand rubs with alcohol concentration of 70% or greater.
- Use alcohol-based hand rub as the preferred method of hand hygiene when hands are not visibly soiled.
- Perform hand hygiene at the point of care.
- Avoid touching contaminated surfaces or objects after performing hand hygiene.
- All employees will perform hand hygiene before, between and after activities that may result in cross-contamination (your Moments of Hand Hygiene).
- Wall mount and stand-alone hand sanitizer stations will be located according to environmental scan [refer to Locations of Hand Sanitizer Stations].

The PIDAC, document, directs that alcohol-based hand rub is the preferred method for decontaminating hands. Using alcohol-based hand rub is better than washing hands (even with an antibacterial soap) when hands are not visibly soiled. The practice document further states, for maximum compliance and use, health care providers should perform hand hygiene at the appropriate moment of care. ABHR should be located at point-of-care, i.e., the place where three elements occur together: the

client/patient/resident, the health care provider and care or treatment involving client/patient/resident contact. Point-of-care products should be accessible without leaving the client/patient/resident. Installing ABHR dispensers at the point-of-care improves adherence to hand hygiene.

The "Just Clean Your Hands" (JCYH) hand hygiene program directs that providing Alcohol-Based Hand Rub (ABHR) at the point of care makes it easier for staff to clean their hands, the right way at the right time. Alcohol-Based Hand Rub dispensers are to be placed within an arm's reach of where care is provided to residents. The JCYH's hand hygiene program indicates that determining the right place for placement of ABHR will differ by unit, resident population group and facility (home) design.

The JCYH document provide tools, specifically a Placement Checklist, to help long-term care staff and management identify the best location for placement of ABHR. The Placement Checklist (JCYH's Tool) directs that the long-term care home should conduct a local risk assessment (page three, point #4) related to ABHR dispensers in resident care areas. Care should be taken for residents who are not mentality capable of realizing the negative effects of ingestion and or misuse of the ABHR. Care should include:
- Resident population
- Dispensers protruding in ways that could cause injury
- Product leakage on surfaces that may result in falls or injuries
- Personal carry (ABHR) as an option.

The Executive Director provided the inspector of undated document tilted “Locations for Hand Sanitizer Stations”. The document included the guidelines for locating/positioning wall mount hand sanitizer stations as follows:
- Resident rooms - the container should be mounted on the wall at the point of care, and the entrance of the room. The container can also be mounted in Resident washroom.

During an interview, the DOC indicated that hand sanitizers stations are installed outside the residents’ rooms with the expectation that staff will use them before entering residents’ rooms. Hand sanitizers stations are available at point of care in resident’s rooms with double beds (greater than two residents), but there were none in private resident rooms. The DOC confirmed that the current placement of hand sanitizers is not according to the guidelines for locating/positioning wall mount hand sanitizer stations provided to the inspector on an identified date. The DOC further indicated that staff do not carry ABHR on their person; but free standing hand sanitizers bottles are available in the long-term care home, but not kept in residents’ rooms.

During an interview, the Executive Director indicated that hand sanitizers are installed in shared rooms at the point of care but not at point of care in private rooms. The Executive Director indicated that there were instructions at the time when hand sanitizers were installed but was unable to provide any details where those instructions came from and at what date.

Both the Executive Director and the DOC indicated that having hand hygiene agents accessible at point-of-care is best practice when following the hygiene program including the guidelines for locations for hand sanitizer stations. [s. 229. (9)]

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 there is a process in place and monitored, ensuring hat staff participate in the implementation of the infection prevention and control program; and that the hand hygiene program is in accordance with evidence based practices and, if there are none, in accordance with prevailing practices, and with access to point of care hand hygiene agents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that the resident's SDM (substitute decision maker) and any other person specified by the resident were notified within twelve hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Related to Intake #015387-17:

Resident #034 was admitted to the long-term care home on an identified date, with history which includes cognitive impairment.

Inspector #672 reviewed resident #034's progress notes, for a period of seven months, which identified that resident #034 had been involved in nine alleged incidents of resident to resident abuse during that time period. According to documentation (progress notes), and interviews with staff members, resident #034's substitute decision maker (SDM) had not been notified of any of the alleged incidents related to resident to resident sexual abuse.

2. Resident #013 was admitted to the long-term care home on an identified date, with history which includes cognitive impairment.

Review of resident #013's progress notes, for a period of approximately five months, identified that resident #013 had been involved in eighteen alleged incidents of resident

to resident abuse during that time period. According to documentation (progress notes), and interviews with staff members, resident #013's substitute decision maker (SDM) had not been notified of any of the alleged incidents related to resident to resident abuse.

Inspector #672 interviewed PSW #122, who indicated that when incidents of responsive behaviours of an identified nature were observed, the residents were separated, and the incidents were reported to registered nursing staffing working on the unit.

Inspector #672 interviewed PSW #126, on, who indicated that when incidents of responsive behaviours of an identified nature were observed, the residents were separated, and the incidents were reported to registered nursing staffing working on the unit.

Inspector #672 interviewed Registered Nurse (RN) #119, who indicated that he/she was informed by the DOC that the SDM of resident #013 consented to the relationship between resident #034 and resident #013, therefore it was believed to be acceptable for these incidents to occur. RN #119 went on to indicate that the SDM of resident #034 had not been upset by a previous incident of responsive behaviours of a identified nature which occurred between resident #013 and resident #034, therefore it was believed resident #034's SDM would also consent to further incidents, therefore there was no need to notify the SDM following each incident of resident to resident identified behaviours. RN #119 could not state why the SDMs for residents #042, #041, and/or #044 had not been notified, but believed this was related to his/her belief that these incidents did not constitute possible resident to resident abuse.

Inspector #672 interviewed the DOC, regarding the documented incidents of resident to resident abuse. The DOC indicated that he/she was aware of periodic episodes of an identified behaviour by both resident #013 and #034, and that staff believe all residents in these situations were willing participants, based on previous incidents of identified behaviour, therefore, they did not believe the incidents were resident to resident abuse, which led to the normalizing of the behaviours, and the decision to not notify the SDMs of any of the residents involved.

Inspector #672 interviewed the DOC (for a second time), along with Inspector #570, where the DOC indicated that the multiple incidents of resident to resident identified behaviours fit the definition of resident to resident abuse, therefore the incidents should have been reported to the SDMs of each of the residents involved.

The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within twelve hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. [s. 97. (1) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Related to Intake #034435-16:

The Executive Director submitted Critical Incident Report (CIR) to the Director, on an identified date, regarding an alleged incident of resident to resident abuse, which was said to have occurred six days earlier.

The CIR indicated that resident #035 grabbed a item which was on resident #036’s mobility aide and resident #036 began to exhibit an identified responsive behaviour towards resident #035. Staff separated the two residents. No injury was noted at time of incident. Identified injury was noted to resident #035 during the physician's assessment, which occurred the same date as the incident.

The CIR indicated the police were notified of the allegation on an identified date, one day after the CIR was submitted to the Director and seven days after the incident occurred and when injury was noted by the physician.

The Executive Director indicated that he/she might have been aware of the incident but was not aware of any injury involving resident #035 until the CIR was submitted on the identified date. The Executive Director further indicated that since an injury was noted and documented in the progress notes, the police should have been immediately notified of the incident. [s. 98.]

Issued on this 19th day of September, 2017

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

Original report signed by the inspector.