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 prévue le Loi de 2007 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 Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jan 12, 2017;	2016_378116_0012 (A1)	018869-16	Resident Quality Inspection

Licensee/Titulaire de permis

ADVENT HEALTH CARE CORPORATION
541 Finch Avenue West NORTH YORK ON M2R 3Y3

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

VALLEYVIEW RESIDENCE
541 Finch Avenue West NORTH YORK ON M2R 3Y3

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

SARAN DANIEL-DODD (116) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This report has been revised to reflect a decision of the Director on a review of the Inspector's order. The Director's review was completed on December 22, 2016. The order was altered to reflect the Director's review.

Issued on this 20 day of January 2017 (A1)

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

Original report signed by the inspector.

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

SARAN DANIEL-DODD (116) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 23, 24, 27, 28, 29, 30, July 4, 5, 6, 7, 8, 11, 12, 13, 2016.

The following critical incident(s) were inspected concurrently with the Resident Quality Inspection (RQI): Log #'s 015300-16, 011664-16, 011976-16, 016214-16, 016583-16, 017881-16, 019197-16, 019363-16.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), nurse manager(s), clinical nurse manager, food services manager (FSM), quality improvement coordinator, environmental service manager (ESM), program manager, office manager, resident and family relation coordinator, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSWs), residents, family members, Power of Attorneys (POA) and Substitute Decision Makers (SDM).

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

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Admission and Discharge

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **17 WN(s)**
- **13 VPC(s)**
- **2 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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On an identified date, the licensee submitted a critical incident report to the Ministry, describing an allegation of staff to resident abuse. The CIS was as follows:

On an identified date, resident #023 who is cognitively well, rang the call bell to request assistance. Staff #126 entered the room and refused to assist the resident. The resident rang the call bell a second time and staff #126 entered the room. The resident requested assistance staff #126 left the room and did not assist the resident. The resident rang the call bell a third time and staff #126 entered into the room and ripped the call bell out of the resident's hand and put the call bell behind the bed and out of reach for the resident. The resident reported soiling himself/herself and fell asleep.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilzation that are performed by anyone other than a resident.

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

Interview with resident #023 revealed that when he/she initially called for assistance, staff #126 entered into the room and said "What" to the resident in a loud tone. The resident reported that staff #126 told him/ her to wait and walked out of the room. The resident reported that he/she waited a length of time and rang the call bell a second time. The resident reported that staff #126 came into the room, lifted the covers off the resident made an identified statement and walked out of the room again. The resident reported being alarmed and disliked staff #126's statement. The resident reported that he/she attempted to assist himself/herself, stood himself/herself up and was unsteady on his/her feet so he/she called for assistance the third time. The resident reported staff #126 entered into the room and removed the call bell out of the resident's hand and was unsure where the staff member placed the call bell. The resident reported that he/she was unable to wait any further and soiled himself/herself. The resident reported that when staff #125 entered into the room during rounds he/she informed staff #125 about the incident.

Interview with staff #125 revealed that he/she entered into the room and resident #023 said "where have you been, I have been calling" and staff #125 informed the resident that he/she has to use the call bell however, upon further notice staff #125 stated he/she observed the call bell was at the back of the bed. Staff #125 asked the resident what happened, and the resident responded staff #126 had taken the call bell away from him/her. Staff #125 stated when he/she checked the resident, identified articles were soiled, and he/she provided assistance to the resident.

The resident reported that the incident made him/her feel very vulnerable and scared, and that the actions of staff #126 were intentional.

Interview with the Director of Care (DOC) and staff #126 revealed that staff #126 was terminated from the home. The DOC confirmed that the resident was not protected from abuse. [s. 19. (1)]

2. On an identified date, the licensee submitted a CIS to the Director reporting that on an identified date, staff #140 (external contract employee) was assigned to provide care to resident #010 who is cognitively intact. Resident #010 reported that he/she rang the call bell for assistance and staff #140 entered the room and responded in an angry tone. Resident #010 stated that he/she requested to go to the washroom and staff #140 told the resident to void in his/her incontinent product.

The written plan of care documents that the resident requires extensive assistance of one person for physical help in weight bearing assistance with toileting.

Resident #010 reported to inspector #116 that he/she initially felt like crying when the staff member directed him/her to void in the incontinent product however, resident #010 insisted to be toileted and staff #140 eventually provided the resident with assistance to the washroom. The home conducted an internal investigation which resulted in the staff no longer being assigned shifts at the home and terminated from the external contracted agency. Staff #140 denied the assertions of neglect. Further interviews held with staff #124, 128, a nurse manager and the DOC confirmed that resident #010 was not protected from abuse by staff #140 on an identified date.

The severity of harm and risk of harm to residents arising from the non compliance resulted in actual harm. The scope of the harm and risk of harm from the non compliance is isolated. The home does not have any outstanding non compliance

issued under s. 19 (1). [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. 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 :

1. The licensee has failed to ensure that 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.
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.

Inspector #652 reviewed a CIS and the progress notes of resident #034 which revealed that an identified staff member documented on an identified date, that during care; resident #034 was noted with an injury to identified areas on his/her body. The assigned PSW stated that the injury was noted at the start of care and was reported to the charge nurse.

Interviews held with the resident care manager and the DOC confirmed that the Ministry was informed of the incident four days after the suspected abuse was reported by the PSW. [s. 24. (1)]

2. On an identified date, while reviewing the electronic nursing documentation of resident #043, inspector #535 discovered that an incident of significance occurred between two assessed cognitively impaired residents, one being highly functional compared to the other. The staff immediately called for support and separated the two residents and documented the incident electronically. Neither resident was assessed for capacity to provide consent to the identified act. During an interview with staff #104 he/she stated they cannot recall reporting the incident to the nursing manager; and during an interview with the nursing manager he/she stated that the incident was not reported to the Director since both residents were cognitively impaired and there was no harm caused to either resident as a result of the incident. The DOC stated that the incident should have been immediately reported to the Director. [s. 24. (1)]

3. On an identified date, a CIS was submitted to the Director related to an allegation of staff to resident abuse that had taken place.

Record review and interview with the DOC confirmed that the alleged staff to resident abuse was not immediately reported to the Director.

The severity of harm arising from the non compliance was minimal harm to risk or potential for actual harm/risk. The scope was pattern and the home currently has an ongoing non compliance with a voluntary plan of correction issued under s. 24 (1). [s. 24. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following right of resident #012 are fully respected and promoted: the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

On an identified date, the licensee submitted a CIS to the Director reporting that on an identified date, staff #124 entered resident #012's room to conduct a search for identified items without receiving prior permission from the resident or the resident's Power of Attorney (POA).
Interviews held with resident #012 and the resident's POA expressed to the

inspector that they were offended that the home did not obtain prior consent to search the room and did not feel the home upheld resident #012's dignity.

An interview held with staff #124 confirmed there was miscommunication between the staff and the resident related to obtaining consent. Further interviews held with nurse managers and the DOC confirmed that the licensee did not promote resident #012's right to be treated with courtesy and respect and in a way that fully recognizes his/her individuality and respects his/her dignity when the room was searched without receiving prior consent. [s. 3. (1) 1.]

2. The licensee failed to ensure the resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

On an identified date, the inspector observed medication administration to resident #014. The inspector observed that the contents of a large plastic garbage container were removed by staff #118. Following the observation, registered staff # 122 was asked how the medication pouches were destroyed in the home and the response was that the pouches were collected and placed in a large plastic garbage container located in the nursing station. Staff #118 stated that after he/she gathers the garbage from the bin in the nursing station, the bag is taken to, and stored in the soiled utility room for removal to the outdoor garbage container located at the back of the building. During an interview with a nurse manager he/she stated that they were aware that the medication pouches contain residents' personal health information (PHI) and that the pouches were being discarded with the regular garbage. The nurse manager further stated that the issue was brought to their attention previously however, they did not have an opportunity to address it. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted:
- to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity and,
- to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 failed to ensure that the home is a safe and secure environment for its residents.

During the inspection, identified prescribed medications and topical creams were observed to be unlocked and stored within identified resident rooms. On the same date, identified prescribed items labelled for an acquaintance of resident #018 who is not a resident of the home were observed to be unlocked and stored within resident #018's room.

An interview held with resident #018 confirmed that the resident was unaware that the identified medications and topical ointment/cream were in his/her possession and that he/she does not administer the oral medications or apply the topicals to self. The resident consented to the removal of the items from his/her room. Interviews held with staff #141, nurse manager(s), DOC and the Administrator confirmed that the identified resident's are not authorized to self administer or store medications within their rooms. Interviews further confirmed that the identified medications and topical creams pose a risk of harm to the residents and others and does not provide a safe and secure environment to all residents of the home. [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 LTCHA, 2007, s. 6. Plan of care Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

Findings/Faits saillants :

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

During stage one of the Resident Quality Inspection (RQI), resident #011 triggered

for prevention of abuse and neglect to be further inspected.

Inspector #116 reviewed the written plan of care created on an identified date, and minimum data set (MDS) quarterly assessment conducted over a specified period, document that no behaviours have been exhibited over the assessment period.

Interviews held with staff #s 100, 103, 138 and 139 informed inspector #116 that resident #011 displays an identified inappropriate behaviour (s) towards the staff. The inappropriate behaviours have been longstanding and not easily redirected. The written plan of care does not identify that resident #011 displays the identified inappropriate behaviour(s). Interviews held with staff #'s 100, 103, a nurse manager and the DOC confirmed that the plan of care does not set out clear directions to staff and others who provide direct care to resident #011 regarding the identified inappropriate behaviours. [s. 6. (1) (c)]

2. Inspector #652 reviewed resident # 034's health care record which revealed on an identified date, the resident was noted to have impaired skin integrity to identified areas.

Inspector #652 reviewed resident #034's progress notes over a specified period which indicated the resident was noted to have impaired skin integrity to different locations of his/her body over the identified period(s).

On an identified date, inspector # 652 reviewed the written plan of care for resident #034 that was in effect during the identified date. The written plan of care did not identify that the resident was at high risk for impaired skin integrity and that resident # 034 was currently on an identified therapy.

On an identified date, inspector #652 reviewed the current written plan of care for resident #034 and noted that the plan of care did not identify that the resident was at high risk for impaired skin integrity.

Interviews held with staff members #100 and #137 on July 13, 2016, confirmed resident #034's written plan of care did not identify that the resident was at high risk for impaired skin integrity and interventions to address care needs. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

During stage one of the Resident Quality Inspection (RQI), resident #002 triggered for an identified care area to be further inspected.

A review of the written plan of care for resident #002 revealed that the resident has resident has a specified condition and directs the staff to ensure that resident #002 has his/her identified visual aid applied each morning.

On three separate dates during the morning, the inspector observed resident #002 seated in the television lounge and not wearing his/her visual aid.

Interview with staff #102 revealed that the resident has not worn the identified visual aid for a while now and does not have the visual aid in his/her room. Interview with staff #100 confirmed that the resident does not wear the visual aid and the visual aid was taken away by a family member.

When staff #100 and the DOC reviewed the current plan of care they confirmed the written plan of care was not revised as the care set out in the plan of care is no longer necessary. [s. 6. (10) (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 the following:
- that the plan of care sets out clear directions to staff and others who provide direct care to the resident and,
- that all residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the residents care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, 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 that the home, furnishings and equipment are kept clean and sanitary.

On three separate dates, identified couches and chairs located within identified resident lounges were observed to be soiled and unclean.

On an identified date, upon entry to an identified unit, a family member of resident #018 brought to the attention of inspector #535 that a couch located in the residents' lounge had been soiled over a three day period and required attention. Inspector #018 had previously observed and documented the soiled couch and brought it to the attention of registered staff #114.

Record review of the home's daily maintenance log located on an identified unit indicated that on a specified date, an entry was made by staff for the maintenance worker to clean the carpet in an identified room. The notation also indicated that the family requested the carpet be cleaned three (3) weeks prior to the identified date to address a lingering odour however; the work had not been completed.

On three separate dates, the inspector observed that an identified resident's ceiling lift cart was unclean on the top and bottom shelves where the resident's transfer device and lift sling are stored. During interviews, staff #120 stated that PSWs are responsible for cleaning the ceiling lift cart in residents' rooms; however staff #121 stated that housekeeping staff are responsible for cleaning the carts. An interview with staff #115 noted that whoever is in the residents' room should clean the ceiling lift carts. A nurse manager, the ESM and the DOC all stated during interviews that neither group are currently assigned the responsibility to clean residents' ceiling lift carts hence the extended period of uncleanliness. [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 that the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, 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 written policy to promote zero tolerance of abuse and neglect of residents is complied with.

On an identified date, resident #009 reported that during a night shift the caregiver roughly turned the resident side to side in bed while providing care. The resident stated that the incident was reported to a staff member. During an interview, staff #110 stated that approximately one month ago the resident informed him/her about an incident which occurred during a night shift. According to staff #110, the resident did not state when the incident occurred or which staff was involved therefore he/she did not report the incident to the registered staff. A Nurse Manager stated during an interview that staff must report all suspected incidents of abuse to the registered staff supervising the unit; and that the incident would have been brought forward to the nurse manager and DOC for further investigation and reporting to the Ministry. [s. 20. (1)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated c. 8, s. 23 (1).

Review of a CIS and progress notes for resident # 034 revealed that an identified staff member documented on an identified date, that during care the resident was noted to have impaired skin integrity to identified areas of his/her body. The assigned PSW stated that the impaired skin integrity was noted at the start of care. The incident was reported to the charge nurse on the same day the impaired skin integrity was observed. The CIS revealed the Director was informed of the incident four days later.

Inspector #652 review of the home's internal investigation notes, employees written statement and interview held with staff #106 revealed an investigation of the incident commenced three days after the initial observation of impaired skin integrity.
Interviews held with the resident care manager and the DOC confirmed that the reported incident of alleged or suspected abuse was not immediately investigated. [s. 23. (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 every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes any mood and behaviour patterns.

During stage one of the Resident Quality Inspection (RQI), resident #011 triggered for prevention of abuse and neglect to be further inspected.

Inspector #116 reviewed the written plan of care and minimum data set (MDS) quarterly assessment conducted over two identified periods, which document that no behaviours have been exhibited over the assessment period.

Interviews held with staff #'s 100, 103, 138 and 139 informed inspector #116 that resident #011 displays inappropriate behaviours towards the staff. The inappropriate behaviours are longstanding and only directed towards an identified gender of staff on the unit. An interview held with staff #100 revealed that the inappropriate behaviours were not communicated to the physician and management of the home. Further interviews held with a nurse manager and the DOC confirmed that an interdisciplinary assessment of resident #011's mood and behaviour patterns was not initiated to address the inappropriate behaviour displayed by resident #001 towards the staff of the home. [s. 26. (3) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes any mood and behaviour patterns, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

During an interview held with the DOC inspector # 535 was informed that the staffing plan evaluation for an identified year was not conducted. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staffing plan is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Resident # 017 wore a specified continence product prior to admission to the home. During an interview with a nurse manager it was revealed that the home's process of assessment includes the use of an electronic clinically appropriate assessment instrument and a three day voiding and bowel movement diary to assess residents continence on admission. Record review showed that resident # 017 did not have an initial admission assessment completed.

During an interview with staff #114, he/she could not locate the missing electronic clinical assessments and applicable three day voiding/bowel movement diary. Staff #114 stated that they may not have been completed for those residents during the residents' admission to the home. A nurse manager stated during an interview that all residents who are incontinent when admitted to the home should have an admission continence assessment completed and placed on a three day voiding and bowel movement diary so that a plan is developed and put in place for each resident. [s. 51. (2) (a)]

2. The licensee has failed to ensure that residents are provided with a range of continence care products that, promote resident comfort, ease of use, dignity and good skin integrity.

On an identified date, the inspector reviewed an external consultant team assessment note for resident #016 in which a recommendation was made for the use of the identified continence product to support the resident's responsive behaviour. The note indicated that the assistant DOC and DOC were informed of the success with the external consultant team trial of the identified continence product with this resident; however the external consultant team was informed that the home does not provide such continence care products for residents. [s. 51. (2) (h) (iii)]

3. Resident # 045 informed the inspector during an interview that a family member

purchases the identified continence product for the resident to wear during the night time and a different identified continence product to wear during the daytime. The inspector contacted and interviewed family member of resident #045 to inquire why the family chose to purchase the identified continence product for the resident instead of using the products available in the home. The family member stated he/she was not aware that the home supplied the identified continence product.

The home distributes a pamphlet to all newly admitted residents which states that a full range of incontinence products to meet residents' needs are provided. Interviews held with nurse managers and the DOC stated that the home offers residents a product for each level of incontinence; and if the resident wants to use an identified continence product instead of the products offered, they can contact the company and order them however, the cost is not covered by the home. Alternatively, the family can bring in the products for the resident to wear. [s. 51. (2) (h) (iii)]

4. A nurse manager provided the inspector with a list of residents residing in the Home who currently use incontinent products. An identified number of residents are listed as ' family supply the identified continence product. The Home's Policy # NMIIC085 Continence Care - Bladder noted that residents are provided with products appropriate to their needs and at no charge to them, however there were currently a specified number of residents' residing in the Home whose families purchased and supplied an identified continence product for use at a cost to those families. [s. 51. (2) (h) (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 the following:
- that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence and,
- residents are provided with a range of continence care products that, promote resident comfort, ease of use, dignity and good skin integrity, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff receives training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

On an identified date, the licensee submitted a CIS to the Director reporting that on an identified date, staff #140 (external contracted employee) was assigned to provide care to resident #010. Resident #010 reported that he/she rang the call bell for assistance to use the toilet and staff #140 directed the resident to void in his/her incontinent product.

An internal investigation was conducted which resulted in staff #140 no longer being assigned shifts at the home and terminated from the external contracted agency. Staff #140 denied the assertions of neglect.

A review of the home's training records revealed and interviews held with nurse managers, DOC and the nursing supervisor of the external contracted agency confirmed that staff #140 (persons who work at the home pursuant to a contract or agreement between the licensee and an employment agency) did not receive training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing assigned responsibilities. [s. 76. (2) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff receives training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities
, to be implemented voluntarily.

WN #13: 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,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of housekeeping, procedures are developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

The home's policies entitled 'Cleaning, Disinfection and Sterilization of Medical/Nursing Equipment/Devices '(Policy# NMIIC060) and 'Lifting Devices: Care and Cleaning' (Policy # ES-VI-20) were reviewed by the inspector and neither policy contains procedures related to the cleaning and disinfection of residents' ceiling lift carts.

The DOC stated during an interview that the ceiling lift carts were delivered by the

vendor with the ceiling lifts to store the device when not in use. The ESM stated that the home's 'Cleaning, Disinfection and Sterilization of Medical/Nursing Equipment/Devices '(Policy# NMIIC060) listed above do not include procedures for the cleaning and disinfection of the ceiling lift carts located in residents' rooms. [s. 87. (2) (b)]

2. On two consecutive dates, the inspector observed resident #002's wheelchair to be visibly soiled.

Staff interviews revealed that the wheelchairs are cleaned by the housekeeping staff and deep cleaned yearly by an outside vendor. Interview with the ESM revealed the home's process is that the nursing department is responsible for identifying which resident's wheelchair(s) require cleaning and to send an email to the ESM. The ESM will then give the list to the housekeeping staff to take the wheelchairs to the laundry room where there is a machine used to steam clean the wheelchair.

Emails provided to the inspector from the ESM noted that an identified staff on an identified unit requested resident #002's wheelchair to be cleaned on two separate dates.

The inspector requested documentation of the completed task and the home's procedure for wheelchair cleaning. There is no documentation or policy related to wheelchair cleaning. It is unclear, based on the home's current process if resident #002's wheelchair was cleaned.

Interview with the ESM confirmed that there is no current procedure or documentation in place to ensure the wheelchairs are kept clean. [s. 87. (2) (b)]

3. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

During the initial tour of the home, resident #015 and #001's rooms had a lingering odour. Observations continued on four separate dates, and both rooms continued to have a lingering odour. Staff #117 whose main responsibility is to clean the floors in the common areas on all units stated that there is no formal housekeeping schedule for steam cleaning inside resident's rooms. The ESM also stated that the home does not have a preventative maintenance schedule in place to steam clean inside residents' rooms nor is there a sign off log for staff to document when work

assigned is completed. [s. 87. (2) (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 procedures are developed and implemented for addressing incidents of lingering offensive odours and,

that as part of the organized program of housekeeping, procedures are developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids, to be implemented voluntarily.

WN #14: 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 :

1. 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.

Inspector #652 reviewed CIS and progress notes of resident #034 on an identified date, indicated that during care resident #034 was noted to have impaired skin integrity to identified areas on his/her body. The assigned PSW stated that the impaired skin integrity was noted at the start of care and was reported to the charge nurse. The CIS indicates the police was engaged and came to facility on an identified date, to get information regarding the incident.

Inspector #652 held an interview with the resident care manager and the DOC confirming that the police were notified. The DOC indicated the home was waiting to speak to an external party who has done investigations of this nature for the home in the past. The DOC did not want to wait for the external party to investigate and as a result, contacted the police liaison and received a voice message back from an identified officer. [s. 98.]

2. On an identified date, the licensee submitted a critical incident report to the Ministry, describing an allegation of staff to resident abuse. The CIS was as follows:

On an identified date, resident #023 who is cognitively well, rang the call bell to request assistance. Staff #126 entered the room and refused to assist the resident. The resident rang the call bell a second time and staff #126 entered the room. The resident requested assistance with toileting and staff #126 told the resident to urinate in his/her incontinent product, left the room and did not assist the resident. The resident rang the call bell a third time and staff #126 entered into the room and ripped the call bell out of the resident's hand and put the call bell behind the bed and out of reach for the resident. The resident reported soiling himself/herself and fell asleep.

Interview with the DOC revealed that staff #126 was terminated from the home and confirmed that the home did not notify the police in relation to the alleged abuse. [s. 98.]

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 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, to be implemented voluntarily.

WN #15: 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. O. Reg. 79/10, s. 229 (4).

a) On an identified date, inspector #652 observed that resident #035 who was on a specified isolation precaution(s) had personal protective equipment stored in an identified area outside the resident's room. The precaution sign on the resident's door indicated gown, mask and gloves were required upon entering the resident's room. Gowns and mask were available in the identified area however, there were no gloves readily available to staff or visitors entering the room.

On the same date, inspector #652 observed in the shared washroom of resident #035 a bin was located next to the toilet. The washroom was unclean and had a strong identified odour. The bin was used to dispose the soiled personal protective equipment (PPE) and other garbage.

Inspector #652 held an interview with staff member #105 on an identified date, who confirmed that gloves were not available in the identified area along with the other PPE however, the PSWs carried gloves on the care carts.

Inspector #652 held interview and observation with staff member #104 on an identified date, who confirmed that resident #035 was on isolation precautions and the PPE is usually stored in the identified area. Staff member #104 confirmed that the precaution sign on the resident's door indicates gloves, mask and gloves were required upon entering the resident's room. Staff member #104 confirmed gowns and mask were available however, there were no gloves readily available to staff or visitors entering the room.

b) Inspector #652 held an interview and observation with staff member #106 on an identified date, who noted and confirmed in the shared washroom of resident #035 a bin was located next to the toilet. The washroom had a strong identified odour. The bin was used to dispose of the soiled PPE and other garbage.

Inspector #652 observed on an identified date, that there were no gowns available to staff on the memory box outside of resident #035's room. Inspector observed staff member #109 at the resident's bedside preparing to assist the resident with feeding. Staff member #109 was not wearing all the required PPE.

Inspector #652 held an interview on an identified date, with staff member #109 who confirmed that the required PPE were not available to carry out the resident's care.

Inspector held interview and observations with staff member #107 who confirmed the required PPE were not available at the time the PSW was providing care to the resident.

c) Inspector #652 held an interview and observation with staff member #150 on an identified date, who noted and confirmed that an identified unlabelled personal care equipment was observed to be soiled and stored on the ground in the resident's shared washroom. A plastic cupboard was also observed in the washroom next to the toilet that contained two identified personal care item(s) that were soiled and a used unlabelled bottle of an identified lotion. Staff member #150 confirmed that the personal care equipment should be cleaned and sanitized as well as the plastic cupboard with the soiled contents. [s. 229. (4)]

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #16: 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.

The Home's Policy # NMIIC085 stated that each resident shall be assessed to detect reversible causes of incontinence; to identify conditions that cause incontinence; and to consider the appropriateness of catheter use. The policy further stated that residents will be observed for three (3) days upon admission for voiding pattern, toilet use, fluid intake, use of appliance and program, cognitive pattern, and mood and behaviour pattern. A review of the following residents record showed that residents # 005, # 009 and # 017 did not have an admission assessment completed; resident # 005 did not have a three day voiding and bowel diary completed on admission and staff # 114 was unable to locate these documents; resident # 009 had a three day voiding and bowel diary started however two days of the voiding diary was incomplete and the bowel diary was never initiated. During an interview with the DOC he/she stated that a continence assessment should be completed for all residents upon admission and quarterly, and that residents who are incontinent should also have a three day voiding/bowel diary completed. [s. 8. (1) (b)]

WN #17: 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 :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

Inspector #652 reviewed resident #034's health care records which revealed on an identified date, the resident was noted to have impaired skin integrity to identified locations on his/her body. Inspector #652 reviewed resident #034's progress notes which revealed a family member of the resident visited the nursing home on identified date, and inquired about the resident's impaired skin integrity. The registered staff member on duty explained to the resident's family what was documented in the resident's progress note on an identified date.

Inspector #652 held an interview with staff member #100 who confirmed that the family member of resident #034 was not immediately notified of the incident regarding the resident's impaired skin integrity .[s. 97. (1) (a)]

Issued on this 20 day of January 2017 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

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TORONTO, ON, M2M-4K5
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SARAN DANIEL-DODD (116) - (A1)

Inspection No. / No de l'inspection : 2016_378116_0012 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 018869-16 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jan 12, 2017;(A1)

Licensee / Titulaire de permis :
ADVENT HEALTH CARE CORPORATION
541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3

LTC Home / Foyer de SLD :
VALLEYVIEW RESIDENCE
541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : MIKE SAVATOVICH

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

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

To ADVENT HEALTH CARE CORPORATION, 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. 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:

1. Develop and implement a plan to facilitate retraining of all direct care staff members on continence care. The plan should include the roles and responsibilities of each staff designated to provide care related to toileting of residents.
2. Develop and implement a plan to facilitate retraining on the homes zero tolerance for abuse policy with focus on staff to resident abuse and neglect and ensure all staff comply with the homes policy.
3. Train/Retrain all staff including agency on the home's continence care and zero tolerance for abuse policies and procedure.
4. Develop and implement a staffing strategy to ensure residents are monitored for toileting requirements during all shifts and specifically the night shift.
5. Develop and implement processes to ensure an immediate investigation is commenced after a report of any abuse by anyone.

The licensee shall prepare, submit and implement a plan for complying with s.19 and identify who will be responsible for completing all of the tasks identified in the order and when the order will be complied with.

This plan is to be submitted via email to inspector: Saran.DanielDodd@ontario.ca on or before November 17, 2016. The date for complying the order shall not be later than December 30, 2016.

Grounds / Motifs :

1. On an identified date, the licensee submitted a CIS to the Director reporting that on an identified date, staff #140 (external contract employee) was assigned to provide care to resident #010 who is cognitively intact. Resident #010 reported that he/she rang the call bell for assistance and staff #140 entered the room and responded in an angry tone. Resident #010 stated that he/she requested to go to the washroom and staff #140 told the resident to void in his/her incontinent product.

The written plan of care documents that the resident requires extensive assistance of one person for physical help in weight bearing assistance with toileting.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilzation that are performed by anyone other than a resident.

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

Resident #010 reported to inspector #116 that he/she initially felt like crying when the staff member directed him/her to void in the incontinent product however, resident #010 insisted to be toileted and staff #140 eventually provided the resident with assistance to the washroom. The home conducted an internal investigation which resulted in the staff no longer being assigned shifts at the home and terminated from the external contracted agency. Staff #140 denied the assertions of neglect. Further interviews held with staff #124, 128, a nurse manager and the DOC confirmed that resident #010 was not protected from abuse by staff #140 on an identified date. (116)

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

On an identified date, the licensee submitted a critical incident report to the Ministry, describing an allegation of staff to resident abuse. The CIS was as follows:

On an identified date, resident #023 who is cognitively well, rang the call bell to request assistance. Staff #126 entered the room and refused to assist the resident. The resident rang the call bell a second time and staff #126 entered the room. The resident requested assistance staff #126 left the room and did not assist the resident. The resident rang the call bell a third time and staff #126 entered into the room and ripped the call bell out of the resident's hand and put the call bell behind the bed and out of reach for the resident. The resident reported soiling himself/herself and fell asleep.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilzation that are performed by anyone other than a resident.

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

Interview with resident #023 revealed that when he/she initially called for assistance, staff #126 entered into the room and said "What" to the resident in a loud tone. The resident reported that staff #126 told him/ her to wait and walked out of the room. The resident reported that he/she waited a length of time and rang the call bell a second time. The resident reported that staff #126 came into the room, lifted the covers off the resident made an identified statement and walked out of the room again. The resident reported being alarmed and disliked staff #126's statement. The resident reported that he/she attempted to assist himself/herself, stood himself/herself up and was unsteady on his/her feet so he/she called for assistance the third time. The resident reported staff #126 entered into the room and removed the call bell out of the resident's hand and was unsure where the staff member placed the call bell. The resident reported that he/she was unable to wait any further and soiled himself/herself. The resident reported that when staff #125 entered into the room during rounds he/she informed staff #125 about the incident.

Interview with staff #125 revealed that he/she entered into the room and resident #023 said "where have you been, I have been calling" and staff #125 informed the resident that he/she has to use the call bell however, upon further notice staff #125 stated he/she observed the call bell was at the back of the bed. Staff #125 asked the resident what happened, and the resident responded staff #126 had taken the call bell away from him/her. Staff #125 stated when he/she checked the resident, identified articles were soiled, and he/she provided assistance to the resident.

The resident reported that the incident made him/her feel very vulnerable and scared, and that the actions of staff #126 were intentional.

Interview with the Director of Care (DOC) and staff #126 revealed that staff #126 was terminated from the home. The DOC confirmed that the resident was not protected from abuse. [s. 19. (1)]

The severity of harm and risk of harm to residents arising from the non compliance resulted in actual harm. The scope of the harm and risk of harm from the non compliance is isolated. The home does not have any outstanding non compliance issued under s. 19 (1).
(189)

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

Dec 30, 2016

Ontario

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

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

(A1)
This order has been altered to reflect a decision of the Director on a review of the inspector's order. The Director's review was completed on December 22, 2016.

The Licensee shall prepare, submit and implement a plan to develop and implement strategies to ensure that any 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:
- Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
- 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.

The plan should include but not be limited to the following tasks:
1. Retraining all staff members of the home on the requirements afforded under s. 24 and the home's policy and procedure for reporting such matters.
2. Identify who will be responsible for completing the retraining and when the task will be completed.
3. Develop and implement processes to ensure an immediate investigation is commenced after a report of any abuse by anyone.
4. Provide education and training to ensure that members of the home's management and all staff are aware of and have a common understanding of

capacity and consent issues in relation to sexual activity between residents, and can demonstrate consistent application through their response to, management and reporting of these incidents.

This plan, relating to points #1 to #3 (inclusive) of inspector's order #002, is to be submitted via email to inspector: Saran.DanielDodd@ontario.ca on or before November 17, 2016.

The date for complying with points #1 to #3 (inclusive) of inspector's order #002 shall not be later than December 30, 2016.

The plan relating to altered point #4 of inspector's order #002, is to be submitted via email to inspector: Saran.DanielDodd@ontario.ca on or before January 20, 2017.

Point #4 of the order must be complied with by: February 24, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that 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.
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.

On an identified date, while reviewing the electronic nursing documentation of resident #043, inspector #535 discovered that an incident of significance occurred between two assessed cognitively impaired residents, one being highly functional compared to the other. The staff immediately called for support and separated the two residents and documented the incident electronically. Neither resident was assessed for capacity to provide consent to the identified act. During an interview with staff #104 he/she stated they cannot recall reporting the incident to the nursing manager; and during an interview with the nursing manager he/she stated that the incident was not reported to the Director since both residents were cognitively impaired and there was no harm caused to either resident as a result of the incident. The DOC stated that the incident should have been immediately reported to the Director. [s. 24. (1)] (535)

2. On an identified date, a CIS was submitted to the Director related to an allegation of staff to resident abuse that had taken place.

Record review and interview with the DOC confirmed that the alleged staff to resident abuse was not immediately reported to the Director.

(189)

3. Inspector #652 reviewed a CIS and the progress notes of resident #034 which revealed that an identified staff member documented on an identified date, that during care; resident #034 was noted with impaired skin integrity to identified areas on his/her body. The assigned PSW stated that the impaired skin integrity was noted at the start of care and was reported to the charge nurse.

Interviews held with the resident care manager and the DOC confirmed that the Ministry was informed of the incident four days after the suspected abuse was reported by the PSW. [s. 24. (1)]

The severity of harm arising from the non compliance was minimal harm to risk or potential for actual harm/risk. The scope was pattern and the home currently has an ongoing non compliance with a voluntary plan of correction issued under s. 24 (1).

(652)

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

Dec 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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
Toronto ON M5S 2B1
Télécopieur : 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 20 day of January 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SARAN DANIEL-DODD - (A1)

Service Area Office /
Bureau régional de services : Toronto