Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 5, 2018	2018_484646_0004	004736-18	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Humber Heights
2245 Lawrence Avenue West ETOBICOKE ON M9P 3W3

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

IVY LAM (646), DEREGE GEDA (645), JUDITH HART (513), JULIENNE NGONLOGA (502), MATTHEW CHIU (565)

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): March 9, 12, 13, 14, 15, 16, 21, 22, 23, 26, 27, 28; April 3, 4, 5, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20; May 2, 2018.

The following critical incidents were inspected concurrently during this inspection:
Log #025261-17/CI #000033-17, Log #004457-18/CI #000009-18 related to transferring and positioning;
Log #025261-17/CI #000033-17, Log #026462-17/CI #000036-17, Log #006878-18/CI #000015-18 related to alleged staff to resident abuse/ neglect;

**Log #025249-17/CI #000032-17 related to responsive behaviours;
Log #011146-17/CI #000018-17 related to pain management;
Log #011146-17/CI #000018-17, Log #021234-17/CI #000026-17, Log #002078-18/CI #000004-18, Log #005582-18/CI #000013-18 related to falls prevention and management;
Log #018634-17/CI #000023-17, Log #024794-17/CI #000031-17 related to personal support services; and
Log #006878-18/CI #000015-18 related to reporting and complaints.**

**The following complaints were inspected concurrently during this inspection:
Log #020392-17, #004206-18 related to reporting and complaints;
Log #020392-17, #026459-17, #024484-17, #002515-18 related to alleged staff to resident abuse/neglect;
Log #020392-17 related to transferring and positioning;
Log #020392-17 related to staff qualifications;
Log #022588-17 related to dining and snack service;
Log #022588-17 related to care conferences;
Log #022588-17, #023370-17; #026132-17, #002656-18, #002515-18 related to personal support services;
Log #023370-17 related to pest control;
Log #025616-17; #026132-17, #029763-17 related to hospitalization and change in condition;
Log #026132-17 related to nutrition and hydration;
Log #026459-17 related to foot and nail care; and
Log #002515-18 related to continence care and bowel management.**

A Written Notification and Voluntary Plan of Action related to LTCHA, 2007, S.O. 2007, C.8, s. 6. (10) (b), identified in concurrent inspection #2018_484646_0005 (Log #001900-18) will be issued in this report.

A Written Notification related to LTCHA, 2007, S.O. 2007, C.8, s. 3. (1) 1., identified in concurrent inspection #2018_484646_0005 (Log #001900-18) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with Acting General Manager (AGM), Director of Nursing (DON), Assistant Directors of Nursing (ADON), Resident Assessment Instrument (RAI) Coordinators, Neighborhood Coordinators (NC), Continence Lead, Skin and Wound Lead, Personal Expression Resource

Team (PERT) Lead, Infection Prevention and Control (IPAC) Lead, Lead Nurse Consultant at Support Office, Registered Dietitian (RD), Food Service Aides, Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Kinesiologist (KIN), Environmental Service Director (ESD), Housekeepers, Nail Care Consultant, Private Caregivers, Residents' Council President, Family Council Co-Chair, Residents, Family Members, Power of Attorneys (POA), and Substitute Decision Makers (SDM).

During the course of this inspection, inspectors conducted a tour of the home, observed residents' care, staff to resident interaction, dining room services, medication administration, reviewed resident health care records and home's records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
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.

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

Findings/Faits saillants :

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

Critical Incident Report (CIR) #2957-000009-18 submitted to the Ministry of Health and Long-Term Care (MOHLTC) indicated that on an identified date, when resident #008 was being transferred, the resident made a lot of physical movements in the an identified mobility device while staff were adjusting an identified assistive device for the resident. The resident sustained an identified injury which required the resident to be sent to the hospital.

Review of resident #008's Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment and plan of care revealed the resident required an identified assistive device for transfer.

Review of the home's incident report on an identified date indicated at an identified time, PSWs #121 and #122 were transferring resident #008 with the identified assistive device and the resident sustained an injury of an identified size and was sent to the hospital.

Review of progress notes from an identified period of time showed that the resident had been resistive to care on four separate dates. The resident was reassessed by Kinesiologist (KIN)#124 for transfer on an identified date, and indicated using a specified assistive device. Further review of the progress notes indicated the resident was still resistive on three other identified dates prior to the above reported incident on the identified date.

Interview with PSW #121 and #122 indicated that PSW #121 provided the morning care to resident #008 on the identified date, and the resident was resistive during care. After calming the resident, PSW #121 and #122 proceeded with the care activity. PSW #121 stated that the resident became resistive to care, and after calming the resident again, the two PSWs continued to proceed with the care. Both PSW's stated that the resident

did not resist care again until they were seated in the specified device. The resident became resistive and hit the device causing it to rebound and hit the resident resulting in an injury.
Interviews with KIN #124, PT #114, and NC #120 indicated a safe technique for using the identified assistive device includes staff to ensure that a resident is not resistive to the identified care before it starts. If the resident is resistive to the identified care, staff should stop and reapproach the resident at another time. If the resident is calm and not resistive later, staff can initiate the identified care using the identified assistive device. PT #114 and NC #120 indicated a post-incident huddle was conducted on the date of the above-mentioned incident. During that time, it was reported that the resident was resistive to the care, and the PSWs did not leave the resident and reapproach the resident at another time in order to make sure the resident was calm and not resistive.

NC #120 confirmed that on the identified date, the home failed to ensure that PSW #121 and #122 used safe transferring techniques when assisting resident #008. [s. 36.]

2. Review of CIS #2957-000033-17, submitted on an identified date, and review of a complaint submitted to the MOHLTC on a subsequent identified date, indicated that resident #041 reported to an identified staff that a team member was rough with them during care. The resident complained of pain on an identified area of their body and upon assessment an identified alteration in skin integrity was noted.

Review of RAI-MDS on an identified date, revealed that resident #041 had modified independence in making decision. The resident also had identified physical limitations.

Review of progress notes indicated that on the identified date of the CIS submission, an alteration in skin integrity was noted on one identified area of resident #041's body, and two other alterations in skin integrity were identified on another identified part of the resident's body. The resident told staff the identified alterations in skin integrity was caused by the staff who worked on an identified shift, and the resident stated they had a lot of pain. When asked what led to the incident, the resident told the staff it was when they called somebody to put them in bed.

Review of the written care plan indicated that resident #041 required two team members for the identified care.

PSW #152 no longer worked at the home at the time of the incident and was not able to be interviewed.

According to the home's investigation notes, PSW #152 had said that on the identified date of the incident, resident #041 called for assistance, and PSW #152 went to assist the resident and found them sitting on the floor of their room. The resident had stood up without assistance and the PSW proceeded to bring the resident to the washroom but the resident did not want to go and was upset. PSW #152 told the resident they needed to change the bed. PSW #152 took the resident to the washroom with an assistive mobility device and brought the resident back to bed.

In an interview, NC #120 confirmed that PSW #152 had toileted the resident without assistance and without the specific identified assistive device on the date of the incident, which resulted in the alteration of skin integrity to the identified part of the resident's body.

According to NC #120, and the AGM, PSW #152 was no longer working in the home as a result of this incident, among other reasons. [s. 36.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on the needs of the resident.

A Critical Incident Report (CIR) #2957-000004-18 submitted to the MOHLTC indicated that resident #007 fell and sustained an identified injury.

Review of resident #007's progress notes and plan of care revealed the resident had both cognitive and physical impairment and required two-person assistance for transfer, and an identified assistive device is required if the resident was not able to do manual transfer. The plan of care also revealed the resident was at risk for falls and a fall prevention plan of care was put in place for the resident.

Interviews with PSW #115 revealed one of the contributing factors for resident #007's risk for falls is the resident may attempt self-transfer. One of the fall prevention interventions had begun to be used by the resident for a period of time.

Interview with Registered Practical Nurse (RPN) #116 indicated resident had been using the identified falls prevention intervention the staff member did not know when it started.

A review of resident #007's care plan together with PSW #115 and RPN #116 indicated the resident's falls prevention plan of care did not set out the use of the identified falls prevention intervention for the resident. RPN #116 further stated the plan of care should be updated as the resident had the needs of using the identified falls prevention intervention.

Interview with Neighbourhood Coordinator (NC) #120 indicated resident #007 started using the identified falls prevention intervention since the resident became at risk for falls, and it was an identified number of months ago. Since the resident might attempt self-transfer and was unsteady, the resident had the needs of using them when the resident falls. During the interview, NC #120 reviewed the resident's falls prevention plan of care and stated the plan of care for using of the identified falls prevention intervention was being revised after it was brought to the staff's attention.

NC #120 confirmed that resident's #007's falls prevention care set out in the plan of care was not based on the resident's needs for using the identified falls prevention intervention. [s. 6. (2)]

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

A CIR #2957-000026-17 submitted to the MOHLTC indicated that on an identified date, resident #009 was found sitting on the floor at an identified home area. An injury was noted on an identified area of the resident's body, and an x-ray was ordered. The x-ray report indicated an identified injury of an identified area of the resident's body, and the resident was taken to the hospital.

Review of resident #009's RAI-MDS assessment, progress notes, and plan of care revealed the resident required an identified level of assistance for specified care activities, and used an identified mobility device as the primary mode of locomotion.

Further review of progress notes and post-fall assessment on the identified date of the incident indicated that resident #009 was found sitting on the floor in an identified resident area. Upon assessment by RPN #153, the resident was found not using an identified falls prevention intervention.

At the time of the fall, resident #009's fall prevention plan of care indicated one of the falls prevention interventions was to use the identified the identified falls prevention intervention daily.

Interviews with PSWs #101 and #154 indicated the resident was at risk for falls. Some of the factors contributing to the resident's risk for falls were attempting self-transfer and unsteadiness on feet. The resident had been wearing the identified falls prevention intervention for a long time. PSW #154 further stated at the time of the above mentioned fall, the identified falls prevention intervention should be implemented for resident #009 already.

Interview with RPN #153 indicated they assessed resident #009 after the above mentioned fall and confirmed the resident was not using the identified falls prevention intervention at that time. RPN #153 stated usually residents had more than one of the identified falls prevention intervention, but RPN #153 did not recall why the resident was not using the identified falls prevention intervention at that time.

Interview with the Director of Nursing (DON) indicated during the time of the above mentioned fall, resident #009 should be using the identified falls prevention intervention according to the fall prevention plan of care. The DNC further stated there was no documentation indicating the resident was using the identified falls prevention intervention at any time that day. The DNC acknowledged that resident #009 was not using the identified falls prevention intervention at the time of the fall as required. [s. 6. (7)]

3. This Responsive Behaviours inspection was initiated related to Critical Incident Report (CIR) #2957-000032-17, related to an incident that occurred between resident #037 and #038 which caused resident #038 to fall. Resident #038 incurred an identified injury to an identified area of their body and was taken to hospital.

Review of resident #037's current plan of care showed that the resident had identified behaviours, with support action including 24hr/7 one-to-one (1:1) companion and

required constant supervision. The care plan also revealed that the resident has verbal and physical expression to others related to cognitive impairment/physical changes, and unpredictable situations/without provocation.

Review of resident's progress notes on an identified date showed that the resident had an order for 1:1 monitoring to begin. Review of resident #037's 1:1 schedule records revealed that resident #037's 1:1 monitoring was adjusted to a specified period of time in the day starting on an identified date. Review of the one-to-one records revealed that on the date of the above-mentioned incident, resident #037 was scheduled to have 1:1 at the same identified period of time.

Interview with PSW #166 revealed that on the day of the incident, PSW #166 was scheduled to work with resident #037, and was doing 1:1 monitoring, when PSW #166 was called by RN #175 to another neighbourhood temporarily for an identified reason. PSW #166 further revealed that they had let the staff on the floor know that PSW #166 had to go downstairs, and then went downstairs. PSW #166 further revealed that they left the neighbourhood without ensuring that there was a staff who would take over the one-to-one monitoring with resident #037.

Interview with RPN #126 revealed that they were aware that RN #175 had requested for PSW #166 to go and assist on another neighbourhood. RPN #126 further revealed that they had told the staff to keep an eye on the resident, but there was no 1:1 staff provided for the resident after PSW #166 left the neighbourhood.

Interview with Registered Nurse (RN) #175 indicated that they had asked PSW #166, who was resident #037's 1:1 staff, to go to another neighbourhood for assistance with an identified issue, and because it was at an identified mealtime, the RN had anticipated that the issue would be resolved by the time resident #037 finished their meal. RN #175 further revealed that resident #037 would have been without the 1:1 between just before meal until just after the incident with resident #038. Review of the CIR revealed that the incident occurred just after the mealtime.

Interviews with NC #125 and Assistant Director of Nursing (ADON) #164 revealed that the 1:1 monitoring for resident #037 is required related to the resident's identified behaviours toward others, and that the resident was not provided with their 1:1 staff as per resident #037's planned care at the time of the incident. Interview with the Acting General Manager (AGM) revealed that resident #037 should have been provided with their one-to-one staff as per the resident's plan of care, and that 1:1 staff should not be

removed from the residents whom they have been assigned to. [s. 6. (7)]

4. The licensee has failed to ensure that the staff who provides direct care to a resident had convenient and immediate access to the contents of the resident's plan of care.

A CIR #2957-000004-18 submitted to the MOHLTC indicated that on an identified date, resident #007 fell and sustained an identified injury.

During the course of the inspection, it was identified that a number of PSWs did not have immediate access to residents' plans of care:
- During the interview, PSW #115 was asked to access resident #007's plan of care. After approximately five minutes, PSW #115 was unable to access the plan of care and indicated they did not have access to the care plan records. After the inspector mentioned that the staff can seek any assistance for accessing the plan of care, PSW #115 went out to the hallway and asked RPN #116 to come to the nursing station for assistance. RPN #116 accessed the plan of care using the nursing station computer.

Interview with ADOC #136 by inspector #646 revealed that the home has changed charting system in on for the registered staff and the PSWs on identified dates in the past year. Prior to the use of the identified charting system, residents' written plans of care were printed and placed in a binder for PSWs to access. After the use of POC, the binder was removed and staff were expected to use the tablet version to view the residents' written plans of care.

Interview with NC #120 indicated PSW had access to the Individual Care Service Plan report (ICSP), a shortened version of the care plan, using the tablet computer. The ICSP is part of the care plan but it does not have the whole content of the plan of care. NC #120 further stated since the PSW was unable to access the full content of the plan of care using their tablet computer and had to ask registered staff or themselves for assistance. If the NC or registered staff are on break, the PSW would have to call the charge nurse on duty in the building for assistance.

NC #120 acknowledged the PSW did not have convenient and immediate access to the contents of the resident's plan of care. [s. 6. (8)]

5. The licensee has failed to ensure that the staff who provides direct care to a resident kept aware of the contents of the plan of care.

CIR #2957-000009-18 submitted to the MOHLTC indicated that on an identified date, when resident #008 was being transferred, the resident made a lot of physical movements in an identified mobility device while staff were adjusting an identified assistive device for the resident. The resident sustained an identified injury which required the resident to be sent to the hospital.

Review of resident #008's RAI-MDS assessment and plan of care revealed the resident required an identified assistive device for transfer.

Interviews with PSWs #121 and #122 revealed the staff had been using the identified personal care item with resident #008's on it when transferring. The staff members indicated all residents may share the identified personal care item on the unit and when the labeled identified personal care item is not available for resident #008, they may use another one without the resident's name. The staff members indicated the size of the identified care item for resident #008 was of a different size than what was in the resident's plan of care. During the interviews, the staff members reviewed the labelled identified care item and the transferring plan of care with the inspector and confirmed the size was what the plan of care said instead of the size quoted by PSWs #121 and #122.

Interview with KIN #124 indicated they had completed an identified assessment for resident #008 and indicated the size of the identified personal care item should be the size identified by the plan of care, and it was care planned. Staff should be aware of the size of the identified plan of care, as they may use an identified personal care item without a resident's name, and the correct size and type is important for resident's comfort and safety.

Interview with NC #120 acknowledged that if staff did not know the correct size of the identified personal care item for resident #008, and they were unaware of the resident's transferring plan of care as required. [s. 6. (8)]

6. The licensee has failed to ensure that the staff who provides direct care to a resident had convenient and immediate access to the contents of the resident's plan of care.

This Continence and Bowel Management inspection for resident #004 was initiated related to worsening bowel or bladder continence from the previous MDS.

During the course of the inspection, it was identified that a number of PSWs did not have immediate access to residents' plans of care:

- During the interview, PSW #106 was asked to access resident #004's continence and bowel management care plan. PSW #106 revealed that they were unable to access the care plan or the Individual Care Service Plan (ICSP) from the tablet, and would have to ask a nurse to access the resident's written plan of care.

- Interview with PSW #101, revealed that they were not aware of how to access the resident's Individual Care Service Plan (ICSP) report or written plan of care on the tablet. PSW #101 further revealed that they would go to the resident's paper chart to find the resident's plan of care, but the resident's binder revealed that it was an old care plan and not the resident's most current care plan revised in March 2018.

Interview with ADOC #136 by inspector #646 revealed that the home has changed charting system in on for the registered staff and the PSWs on identified dates in the past year. Prior to the use of the identified charting system, residents' written plans of care were printed and placed in a binder for PSWs to access. After the use of POC, the binder was removed and staff were expected to use the tablet version to view the residents' written plans of care.

Interview with NC #120 indicated PSW had access to the ICSP, a shortened version of the care plan, using the tablet computer. The ICSP is part of the care plan but it does not have the whole content of the plan of care. NC #120 further stated since the PSW was unable to access the full content of the plan of care using their tablet computer and had to ask registered staff or themselves for assistance. If the NC or registered staff are on break, the PSW would have to call the charge nurse on duty in the building for assistance.

NC #120 acknowledged the PSW did not have convenient and immediate access to the contents of the resident's plan of care. [s. 6. (8)]

7. This inspection for skin and wound care was initiated for resident #006 related to identified alterations of skin integrity as part of the RQI inspection.

During the course of the inspection, it was identified that a number of PSWs did not have immediate access to residents' plans of care:
- During the interview, PSW #131 was asked to access resident #006's skin and wound care plan on the tablet. PSW #131 attempted to access the ICSP on the tablet for approximately ten minutes, but was unable to do so, and had gone to the RAI

Coordinator #139 to show PSW #131 how to access the ICSP.

- Interview with PSW #132 revealed that the PSW was able to access the resident's ICSP on the tablet, but does not have access to the full care plan for residents. PSW #132 further revealed that there was a binder for PSWs to view residents' full written care plans before but that has been taken away, the PSW would have to go to a registered staff to see the resident's written care plan.

Interview with ADOC #136 by inspector #646 revealed that the home has changed charting system in on for the registered staff and the PSWs on identified dates in the past year. Prior to the use of the identified charting system, residents' written plans of care were printed and placed in a binder for PSWs to access. After the use of POC, the binder was removed and staff were expected to use the tablet version to view the residents' written plans of care.

Interview with NC #120 indicated PSW had access to the Individual Care Service Plan report (ICSP), a shortened version of the care plan, using the tablet computer. The ICSP is part of the care plan but it does not have the whole content of the plan of care. NC #120 further stated since the PSW was unable to access the full content of the plan of care using their tablet computer and had to ask registered staff or themselves for assistance. If the NC or registered staff are on break, the PSW would have to call the charge nurse on duty in the building for assistance.

NC #120 acknowledged the PSW did not have convenient and immediate access to the contents of the resident's plan of care. [s. 6. (8)]

8. The licensee has failed to ensure that the following are documented: 1. The provision of the care set out in the plan of care. 2. The outcomes of the care set out in the plan of care.

During the course of the RQI inspection, the plan of care for resident #051 was reviewed. A review of the physician's orders for resident #051 on an identified date indicated that vital signs were to be taken every shift (every eight hours) for an identified number of days.

A review of the progress notes and vital sign record for resident #051 from an identified

number of days revealed the vital signs were documented as taken on the following dates and times:
• Identified Day 1: 0512 hours
• Identified Day 2: 2122 hours
• Identified Day 3: 0014, 0752, and 2011 hours
• Identified Day 4: 1155 and 2158 hours
• Identified Day 5: 0035, 0042, 0854, 1314, and 2300 hours
• Identified Day 6: 1500 hours
• Identified Day 7: 0921 and 2125 hours
• Identified Day 8: 1255 hours
• Identified Day 9: 0500, 0547, and 2059 hours

Resident #051's vital signs were not documented as taken as per the physician's plan of care.

An interview with RPN #119, who reviewed the vital signs record and progress notes for resident #051, confirmed the vital signs were not recorded for the above identified dates.

An interview with the DON confirmed the expectation of the home was to record the vital signs when taken and in this instance the provision of care as set out in the written plan of care was not documented. [s. 6. (9)] (513) [s. 6. (9) 1.]

9. This Responsive Behaviours inspection was initiated related to CIR #2957-000032-17, related to an incident that occurred between resident #037 and #038 which caused resident #038 to fall. Resident #038 incurred an identified injury to an identified area of their body and was taken to hospital.

Review of resident #037's current written plan of care revealed that the resident exhibited responsive behaviours. Review of resident #037's progress notes on an identified date prior to the incident showed that resident #037 had an incident with a staff member and an identified monitoring system was initiated.

Review of the identified monitoring system the week after it was initiated showed that there were missing documentation on four days during identified shifts.

PSW #167 who was resident #037's 1:1 staff on two shifts during the monitoring period, stated that it is usually the registered staff who would inform them of any residents who were on identified monitoring that required identified charting, but they were unable to

complete the documentation for the resident as the resident was walking around and the PSW had to take the resident downstairs to walk and did not have time to complete the identified charting for resident #037.

Interview with RPN #105 revealed that the registered staff learn of residents who will be on the identified monitoring system during shift reports. RPN #105 revealed that they had worked on one of the days where the documentation was missing, and would usually review information from the previous 24 hours, but there were no instructions written in the progress notes or the nursing book for staff for the previous 24 hours prior to that date regarding resident #037's identified monitoring, and the RPN may not have provided the PSW information regarding completion of the identified charting for resident #037.

NC #125 and the AGM stated that the use of the identified monitoring is to identify a time pattern for when resident's personal expression and incidents happen. The AGM further stated that it was the home's expectation for identified monitoring documentation to be completed if it is assigned for a resident, and registered staff or NCs should review to ensure the documentation is done for each shift. NC #125 and the AGM revealed that the DOS was not completed for resident #037 as per resident's plan of care. [s. 6. (9) 1.]

10. This Responsive Behaviours inspection was initiated as part of the sample expansion when a non-compliance was found.

Review of resident #039's incident report showed that resident #039 had entered an identified residents' area and had an altercation with a co-resident. No injuries were found on either resident, and an identified monitoring system with documentation was initiated.

Review of resident #039's identified monitoring system documentation for an identified one-week period showed that there were missing documentation on identified shifts for all seven days.

Interview with RPN #105 revealed that the registered staff would become aware of residents who are to be on the identified monitoring system with required documentation during shift reports. RPN #105 revealed that they would review information from progress notes and the nursing book from the previous 24 hours at the start of their shift. RPN #105 revealed they did not recall being notified that resident #039 would be on the identified monitoring system over the past couple of weeks.

NC #125 and the AGM stated in interviews that the use of the identified monitoring system was to identify a time pattern for when resident's personal expression and incidents happen. The AGM further stated that it was the home's expectation for the identified monitoring documentation to be completed if it was assigned for a resident, and registered staff or NCs should review to ensure the documentation is done for each shift. NC #125 and the AGM stated that the documentation was not completed for resident #039 as per the resident's plan of care. [s. 6. (9) 1.]

11. This Responsive Behaviours inspection was initiated related to an incident that occurred between resident #037 and #038 and resident #038 had a fall with an identified injury.

Review of resident #038's current written plan of care showed that the resident had identified personal expressions. Review of resident #038's progress notes showed that an identified monitoring system with required documentation began for the resident on an identified date.

Review of the required documentation for resident #038's monitoring for the 7-day period showed that there was missing documentation for two days on identified shifts. Interview with RPN #105 revealed that the registered staff would become aware of residents who are to be on the identified monitoring during shift reports. RPN #105 revealed that they would review information from progress notes and the nursing book from the previous 24 hours at the start of their shift. RPN #105 revealed they did not recall being notified that resident #038 would be on the identified monitoring over the past couple of weeks.

NC #125 and the AGM stated that the use of the identified monitoring was to identify patterns and triggers for the resident, and to identify what triggers the behaviours. NC #125 stated that resident #038's DOS was not completed and should have been completed as it was part of resident #038's planned care. The AGM further stated that it was the home's expectation for the identified monitoring and documentation to be completed if it was assigned for a resident, and registered staff or NCs should review to ensure the documentation as done for each shift. The NC #125 and the AGM stated that the identified monitoring was not completed for resident #038 as per the resident's plan of care. [s. 6. (9) 1.]

12. Review of a complainant submitted to the MOHLTC on an identified date indicated that resident #043 was transferred to the hospital two times within a short time with

specified health concerns. The complainant raised concerns regarding monitoring of the resident's health.

Review of RAI-MDS revealed that resident #043 was moderately impaired related to poor decisions. The resident is total dependence and was at an identified level of mobility. According the resident's written plan of care resident #043 was incontinent of bowels, their bowel pattern was identified, and staff are to record the bowel movements.

Review of the documentation survey report revealed that the resident had identified formed bowel movements on evening and night shift daily.

According to the progress notes, on an identified date, resident #043 was observed with a change in health status, with identified symptoms and the resident was transferred to the hospital.

According to the physician discharge summary, the identified scan done in the hospital showed an identified clinical sign.

Review of the physician order indicated that resident #043 had bowel protocol in at the time of the incident that included nine progressive interventions related to the number of days the resident did not have a bowel movement, or as needed.

Review of the eMAR revealed that the above bowel protocol was not implemented with the exception of the first two identified interventions.

According to RPN #170, Nurse Practioner (NP) #172 and AGM #151, the protocol was not initiated because the documentation of the PSWs were not accurate, which did not alarm the registered nursing staff to implement the above bowel protocol. As result all PSWs had been trained in recording the bowel movement of the resident. [s. 6. (9) 2.]

13. This inspection for skin and wound care was initiated for resident #006 related to identified altered skin integrity, triggered from the staff interview and from the census record review.

Review of resident #006's current care plan on an identified date showed that the resident was to receive showers at two identified times of the week. Review of the resident's care report for an identified month showed that bathing support was given, and indicated an identified type of bathing.

Interviews with PSWs #130 and #143 revealed that resident #006 remains in bed, and the resident has been provided bed baths in their room and has not received the identified bathing care since shortly after their admission four months prior, as the resident is bedridden due to their identified altered skin integrity. Interview with RPN #141 revealed that resident #006 remains in bed and all care is provided for the resident in their room, and that resident #006's care plan is not up-to-date.

Interview with NC #120 revealed that as per resident #006's care plan, they are to be provided an identified type of bathing care, and staff members should have communicated and updated the resident's written plan of care when the resident's bathing care had changed. Interview with the AGM revealed that the home's expectation is for resident's care plan to reflect the current care the resident receives, and that resident #006's written plan of care was not updated when their care needs for bathing changed. [s. 6. (10) (b)]

14. The licensee has failed to ensure that the plan of care was revised at any other time when care set out in the plan has not been effective.

An identified intake submitted to the MOHLTC indicated that on an identified date, resident #009 was found sitting on an identified surface in an identified residents' area. Redness was noted on the right knee upon examination and x-ray to the knee was ordered. The x-ray report indicated an identified injury on an identified part of the resident's body, and the resident was taken to the hospital on the same day.

Review of resident #009's RAI-MDS assessment and plan of care revealed the resident had cognitive and physical impairment, and they required an identified mobility device with identified level of assistance for transfer and ambulation. Resident #009 was at risk for falls and the progress notes in an identified four-month period showed that the resident fell eight times, and had sustained injuries during three of the eight falls.

Further review of resident #009's falls prevention plan of care, including the progress notes, indicated the resident had the following care implemented as of the time of the first fall:
- Develop a toileting plan with resident as they attempt to toilet themselves and will require this for safety.
- Resident started with toilet training for every two hours.
- Put fall mat beside the resident's high low bed that is in the lowest position.

- Review lift and transfer techniques. Ensure appropriate pictogram at the head of the bed.
- When the resident gets up from chair, assist the resident to sit back to wheelchair. If someone see that the resident is halfway walking, call for help. When help arrives, assist the resident to sit back to wheelchair. If resident is falling, assist the resident to fall.
- Reinforce the needs to call for assistance.
- Resident to wear proper and non-slip footwear.
- Hip protectors to be worn daily.
- DOS charting for increased monitoring.

The above mentioned falls prevention plan of care was not revised other than an identified monitoring system was discontinued on an identified date as indicated in the progress notes that the resident was ambulating with an identified mobility device and not many falls were noted, along with toileting the resident at an identified frequency of time, and as needed.

Interviews with PSWs #101 and #154 indicated resident #009 was at risk for falls, and stated specific factors contributing to the resident's risk for falls. PSW #154 further stated the falls prevention care mentioned above helped did not stop the resident from falling. The staff had no recollection that the falls prevention plan of care had been revised during the above mentioned period.

Interview with RPN #102 indicated the resident had multiple falls and used to fall more often. The falls prevention plan of care helped prevent falls but was not effective to stop resident from falling, and the resident continued to fall and sustained injuries. The staff further stated except for the identified monitoring system that was discontinued on an identified date, the falls prevention plan of care was not revised during the above mentioned period.

Interview with NC #155 indicated resident #009's number of falls had either plateaued or was less than before, and the resident had continued to experience falls. NC #155 stated one of the goals for the falls prevention plan of care was to have no injury from falls and the care set out was unable to prevent every single injury for resident #009. NC #155 further stated the plan of care might be more effective if it says minimize injury or no serious injury.

Interview with the DNC indicated the goal for a falls prevention plan of care is to prevent falls. Resident #009's fall prevention plan of care was able to reduce the number of falls

when compared to approximately the same time last year. But it was unable to prevent resident #009 from falling and the resident had sustained injuries from falls. The DNC indicated that no further revision of the falls prevention plan of care was made after the removal of the identified monitoring system on the identified date. The DNC acknowledged that the falls prevention plan of care for resident #009 was not revised when the care set out was ineffective. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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:
1) The care set out in the plan of care was based on the needs of the resident,
2) The care set out in the plan of care was provided to the resident as specified in the plan,
3) Staff and others who provide direct care to a resident, kept aware of the contents of the plan of care and have convenient and immediate access to it,
4) The following are documented: 1. The provision of the care set out in the plan of care. 2. The outcomes of the care set out in the plan of care. 3. The effectiveness of the plan of care,
5) Residents are 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, and
6) The plan of care was not revised at any other time when care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that doors leading to non-residential areas were locked when they were not supervised by a staff.

On the initial tour of the home on an identified date, inspector #565 observed a linen room on an identified floor was unlocked. The door was equipped with a mechanical keypad lock and the door was closed but unlocked. No staff members were observed in close proximity at the time. On another identified date, inspector #645 observed the following doors were closed but not locked:

- Dirty utility room on an identified floor
- Linen door room on an identified floor, and
- Utility room on an identified floor.

The doors were shut but unlocked, residents were ambulating in the area and staff were not observed in close proximity. All the doors are equipped with mechanical keypad locking mechanism but the system was not locking all the time. Both the dirty utility and linen room's door had a sign that specifies "Authorized Personnel Only", allowing access only to staff members. Inspector #645 was able to open the above mentioned doors without entering the codes.

An interview with RPN #105 confirmed that the Linen room on the identified floor was unlocked. RPN #105 made several attempts to lock the door but failed. He/she indicated the door was supposed to be locked at all times to prevent resident from entering. They stated that they would send out a maintenance request to get the lock fixed.

An interview with PSW #107 and RN #108 confirmed that the linen and dirty utility rooms were unlocked and were accessible to residents. They both reiterated that it is the expectation of the home to have the door locked all the time to prevent residents from accessing it. They stated that they would send a maintenance request to have the door lock fixed.

An interview with Environmental Service Director (ESD) confirmed that the door locks to both the clean Linen and dirty utility room do not lock all the time. The ESD reiterated that the doors were expected to be locked all the time. They stated that they would send out a maintenance request to have the door fixed. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that doors leading to non-residential areas were locked when they are not supervised by a staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from neglect by the licensee or staff in the home.

In accordance with the definition in subsection 2 (1) 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, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

Review of a complaint submitted to the MOHLTC on an identified date indicated that a week prior, the resident alleged that they were told by staff to wait when they asked the staff for assistance at 0930 hours to be changed after an incontinence episode. The PSW returned at 1200 hours and the resident requested again to be changed, the staff told them to wait until after lunch and then brought the resident to the dining room with soiled continence care product. After lunch the resident was brought back to their room and left to wait until 1330 hours when they were provided assistance in changing their continence care product.

Review of RAI-MDS completed on an identified date, indicated that resident #042 was independent in making consistent and reasonable decisions. According to the RAI-MDS

assessment and the resident's written plan of care, resident #042 was incontinent and will tell staff when they want to be changed, and they required extensive to total assistance from two staff members.

On another identified date at 1045 hours the resident declined to answer the questions related to the incident and told the inspector that there was no use in complaining. In a phone interview, the complainant confirmed the allegation identified above.

In an interview, PSW #150 confirmed that resident #041 requested assistance to be changed at approximately 0930 hours, as they were going to their break and the resident told them that they can wait until after the PSW's break. PSW #150 indicated that after the break they had to serve morning snack, then they had three residents in bed that needed to get up. They returned to resident #041 almost at lunch time and the resident agreed to wait after lunch time when the resident would be transferred back to bed for their nap. PSW #150 stated that resident's continence care product was soiled with feces and urine at the time they provided assistance and that the resident was mad.

In an interview, PSW #146 stated that RPN #123 informed them that the resident needed to be changed. They told the RPN that they were busy and they will change resident #042 after completing the care of another resident. After completing the care, both PSWs #146 and #150 went for break and returned just before lunch time. PSW #146 stated that the resident told them they were upset.

In an interview, RPN #123 confirmed that resident #042 had requested assistance with toileting around 1030 hours, they informed the PSWs who were providing shower to another resident. RPN #153 indicated that they should have endorsed the care to other PSWs on the floor or to inform the neighborhood coordinator as the assigned PSWs were providing care to another resident and it was more than one hour that resident #042 requested for assistance.

In an interview, NC #120 stated that on an identified date, resident #042 asked how long the staff break was, and they replied 30 minutes. The resident then stated that on a previous identified date, at 0930 hours, they wanted to be changed and staff were not available. At 1045 hours PSW #150 approached and told them that they will come back. The PSW returned just before lunch and told the resident that they would assist them after lunch and wheeled them in the dining room. The resident said the staff toileted them at 1330 hours. NC #120 stated that the resident felt bad and was upset.

In an interview, AGM #151 stated that the home's expectation was for staff to provide assistance within 10 to 15 minutes after the staff become aware of the resident need and that staff should change the break to provide assistance. AGM #151 acknowledged that the care was inappropriate and incompetent as assistance was not provided until four hours after their initial request for assistance and the resident was left having their lunch with continence care product soiled with urine and feces. [s. 19. (1)]

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

In accordance with the definition in subsection 2 (1) of the Act “physical abuse” means, subject to subsection (2): (c) the use of physical force by a resident that causes physical injury to another resident; (“mauvais traitement d’ordre physique”).

This Responsive Behaviours inspection was initiated related to CIR #2957-000032-17, related to an incident that occurred between resident #037 and #038 which caused resident #038 to fall. Resident #038 incurred an identified injury to an identified area of their body and was taken to hospital.

Review of resident #038’s written plan of care updated on an identified date prior to the incident showed that the resident had identified personal expressions, and also had a tendency to wander.

Review of resident #037's written plan of care on another identified date prior to the incident showed that interventions in response to resident #037’s behaviours included 24hr/7 one-to-one (1:1) companion and constant supervision. The care plan also revealed that the resident has verbal and physical expression.

Review of resident’s progress notes on an identified date showed that the resident had an order for 1:1 monitoring to begin. Review of resident #037’s 1:1 schedule records revealed that resident #037’s 1:1 monitoring was adjusted to a 16-hour period, starting on an identified date. Review of the 1:1 monitoring records revealed that on the day of the incident, resident #037 was scheduled to have 1:1 during the same 16-hour period.

Interview with PSW #166 showed that on the day of the incident, PSW #166 was scheduled to work with resident #037, and was doing 1:1 monitoring until around breakfast time, when PSW #166 was called by RN #175 to another secure

neighbourhood temporarily for another identified concern. PSW #166 further indicated that they had let the staff know on the floor that they have to go to the other neighbourhood, and went. PSW #166 further indicated that they left the neighbourhood without ensuring that there was a staff who would take over the 1:1 monitoring with resident #037.

RPN #126 stated in an interview that they were aware that RN #175 had requested for PSW #166 to go and assist on another neighbourhood. RPN #126 further revealed that they had told the staff to keep an eye on the resident, but there was no 1:1 staff provided for the resident after PSW #166 left the neighbourhood.

RN #175 indicated in an interview that they had asked PSW #166, resident #037's 1:1 staff, to come to assist with an identified issue at the time of the incident, and because it was breakfast time, RN #175 had anticipated that the issue would be resolved by the time resident #037 finished their breakfast. RN #175 further revealed that resident #037 would have been without the 1:1 between just before breakfast until just after the incident with resident #038. Review of the CIR revealed that the incident occurred at approximately 1000 hours.

Interview with PSW #176 revealed that they were assisting another resident outside the dining room, and had observed resident #037 and #038 ambulating at an identified area of the home, and no PSWs were around. The PSW revealed that there was an altercation between the two residents and resident #038 fell.

Interview with NC #125 revealed that they were at the nursing station at the time of the incident, and had seen the incident where resident #037 pushed resident #038, who fell and hit the wall, resulting in a an identified injury to an identified part of resident #038's body. NC #125 further stated that resident #037's 1:1 was pulled away at the time of the incident, and there was no staff who was doing the 1:1 with resident #037 at the time. NC #125 further stated that resident #037 required 1:1 related to their identified responsive behaviours, which may be unpredictable.

NC #125 and ADOC #164 indicated in interviews that the 1:1 monitoring for resident #037 was required related to the resident's identified responsive behaviours toward others. They further indicated that resident #037 was not provided with their 1:1 staff at the time of the incident on the identified date, and had pushed resident #038, who had sustained an injury as a result and had to be taken to the hospital.

Interview with the AGM revealed that resident #037 should have been provided with their 1:1 monitoring as per the resident's plan of care, and resident #038 was not protected from physical abuse of resident #037, who was known to have physical aggressive personal expressions. [s. 19. (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 residents are protected from neglect by the licensee or staff in the home,, 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 :

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

CIR #2957-000023-17 submitted to the MOHLTC indicated that on an identified date,

resident #008 was noted to have a specified injury on an identified area of their body, and the resident was sent to hospital for an identified medical procedure, but no medical condition was identified. The resident continued to have pain in the same identified area and injury had worsened. The resident was reassessed and a repeat of the medical procedure was ordered. The repeated medical procedure indicated that there was an identified medical condition.
Review of resident #008's RAI-MDS assessment and plan of care indicated the resident had cognitive and physical impairment.

Review of resident #008's progress notes, incident report, assessment and clinical records revealed no records of investigations being conducted by the home to identify the cause of the identified medical condition. The progress notes on an identified date indicated the resident's identified injuries were reported by the resident's family member on that day.

Interview with an identified family member of resident #008 indicated that they had reported the incident sometime after resident #008's identified medical condition was diagnosed, to NC #120 that the resident had indicated to them an identified PSW hit the resident and caused the pain. The family had suspected abuse of the resident.

Interview with NC #120 revealed they were away for an identified period after the incident. When NC #120 returned, they were told by the identified family member that resident #008 pointed at a staff member and indicated the staff caused the resident the pain. NC #120 indicated the family suspected an abuse had happened to the resident and NC #120 told the family member that they will look into this.

NC #120 further stating they are one of the leadership team members who is responsible to report to the Director and launch an investigation immediately when someone reported a suspicion of a resident abuse. NC #120 confirmed that they did not report the suspicion to the Director.

Interview with the AGM indicated the home's expectation for reporting a suspicion of resident abuse is that when someone has reasonable grounds to believe an abuse had happened and reported the suspicion to one of the leadership team members, the team member should immediately report the suspicion to the Director. The AGM confirmed that the home failed to report the suspicion of abuse towards resident #008 as required. [s. 24. (1)]

2. Review of a complaint submitted to the MOHLTC indicated that the resident #042 alleged that they were told by staff to wait when they asked the staff for assistance at 0930 hours to be changed after an incontinence episode. The PSW returned at 1200 hours and the resident requested again to be changed, the staff told them after lunch and then brought the resident to the dining room with soiled continence care product. After lunch the resident was brought back to their room and left to wait until 1330 hours when they had provided assistance in changing the continence care product.

In an interview the complainant indicated that they had informed the NC #120 about the alleged abuse.

NC #120 indicated that their job responsibility include reporting any allegation of abuse and neglect to the home's management and the MOHLTC. They confirmed that the resident and resident's Substitute Decision Maker (SDM) had told them about the allegation of neglect identified above, but they had not reported the allegation of neglect to the home management team or the MOHLTC. [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 that a person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The home has failed to inform the Director no later than one business day after the occurrence of an incident, subject to subsection (3.1), that causes an injury to a resident for which the resident was taken to a hospital and that results in a significant change in the resident's health condition.

A CIR #2957-000026-17 submitted to the MOHLTC indicated that on an identified date,

resident #009 was found sitting on the floor in an identified residents' area. An identified injury was noted upon examination, and an identified medical procedure was ordered. The identified medical procedure indicated an identified medical condition, and the resident was taken to the hospital. The CIR was first submitted to the Director four days after the results were received.

Review of resident #009's progress notes indicated the identified medical procedure was ordered the day after the resident's fall, and the procedure was done the day after, with the results received one day after the procedure was completed to identify that the resident had a medical condition, and the resident was sent to the hospital.

Interviews with the DON and the AGM indicated on the day the resident was sent to the hospital, the home was aware of a significant change of the resident's health condition as a result of the injury. The staff further confirmed since the resident was taken to the hospital on the identified date, the home should report the incident to the Director within one business day, had not reported the incident. [s. 107. (3)]

2. The licensee, who is required to inform the Director of an incident under subsection (1), (3) or (3.1), has failed to ensure that within 10 days of becoming aware of the incident, or sooner if required by the Director, made a report in writing to the Director setting out the following with respect to the incident:
- Analysis and follow-up action, including, (i). the immediate actions that have been taken to prevent recurrence, and (ii), the long-term actions planned to correct the situation and prevent recurrence.

CIR #2957-000023-17 submitted to the MOHLTC indicated that on an identified date, resident #008 was noted to have identified injuries and was sent to hospital for an identified medical procedure, but no medical condition was identified from the procedure. The resident continued to have pain in the identified area of the body and the injuries appear to have worsened. The resident was reassessed and a repeated medical procedure was ordered. The results came back four days later which indicated an identified medical condition.

Further review of the CIR submitted by NC #125 indicated the home had not reported the immediate actions that have been taken to prevent recurrence, and stated 'resident and environment will be assessed to determine possible causes' under the long-term actions planned to correct the situation and prevent recurrence.

Review of resident #008's progress notes, plan of care, incident report, assessment records, and the home's records did not reveal investigation records to identify the causes of the identified medical condition, and no actions were being identified to prevent recurrence.

Interview with NC #125 indicated they did not recall why they did not report the immediate actions that have been taken to prevent recurrence. NC #125 further stated in order to identify the action to prevent recurrence, the home had to identify the cause of the identified medical condition. Therefore, when submitting the CIR, they stated the home will determine the possible cause. NC #125 indicated they did not follow-up on the action and could not recollect whether or not an investigation was conducted to determine the possible cause of the identified medical condition. NC #125 was unable to identify any investigation records to identify the possible cause.

Interview with AGM indicated there was no investigation being conducted to identify the possible cause of the identified medical condition. The AGM acknowledged that the home had to identify the possible cause in order to plan action for preventing recurrence. The AGM confirmed since no investigation was conducted, the home had not planned the long term action to correct the situation and prevent recurrence, and therefore no action was reported. The AGM further confirmed the home had not reported the immediate action that had been taken to prevent recurrence as required. [s. 107. (4) 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:
1) The home informs the Director no later than one business day after the occurrence of an incident, subject to subsection (3.1), that causes an injury to a resident for which the resident was taken to a hospital and that results in a significant change in the resident's health condition
2) The licensee, who is required to inform the Director of an incident under subsection (1), (3) or (3.1), would make a report in writing to the Director setting out the following with respect to the incident within 10 days of becoming aware of the incident, or sooner if required by the Director, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are treated with respect and dignity in a way that fully recognizes the resident's individuality.

Two complaints were received by the MOHLTC from a complainant regarding an alleged incident of improper care of residents #022 and #023 by PSW #118, specifically related to improper care of resident #023 where staff PSW #118 fed the resident in the dining room and at the same time was documented on the work IPAD. The resident had not swallowed their food, and their mouth was full. The PSW had not paid attention to the resident, as they were occupied with documenting, then was observed to forcefully put their finger in the resident's mouth and scoop the food out. The second complaint alleged an incident of abuse where the same PSW pushed resident's #022 wheelchair's away in an attempt to redirect the resident. There was no injury to either resident.

In an interview, the complainant stated that neither resident was treated with respect and dignity. The complainant stated staff should not be doing documentation while feeding residents and should not push residents away when a resident asked for something. PSW #118 forcefully turned resident #022's away to redirect the resident to their room and stated "I am busy can't you see." The complainant stated it was disrespectful not to address the resident's wishes. The complainant stated there was no injury but reiterated that the PSW did put them at risk in both cases and their action lacked dignity and respect.

Record review of the home's investigation notes showed that the PSW was disciplined for not treating both residents with respect and dignity, and putting both residents at risk of harm. There was no injury to either resident.

Interviews with NC #125 and AGM indicated that PSW #118 was documenting while feeding resident #023 and also pushed resident #022's wheelchair away. NC #125 confirmed that there were no injuries to either resident but the staff engaged in a conduct that is not aligned with the home expectation. Residents have the right to receive appropriate care and staff are required to treat resident with respect and dignity. The PSW's action lacked dignity and respect to the residents. As a result, disciplinary action was taken. [s. 3. (1) 1.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that 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.

The home's Prevention of Abuse and Neglect Policy, last reviewed December 6, 2017, states: Any person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and information upon which it is based to their immediate supervisor or any member of the leadership team.

Review CIR # 006878-18 indicated a report was made to the MOHLTC regarding an incident that occurred on an identified date regarding an injury that was noticed on resident. The resident stated that it was due to an identified action by PSW #174. An investigation was started and PSW #174 was on administrative leave pending investigation.

A review of the progress notes revealed that on an identified date, the incident about the identified injury was reported to the MOHLTC.

A review of the Progress Notes and Incident Report on an identified date indicated that resident #052 alleged PSW #174 had pushed the resident, resulting in an identified injury. During the change of shift report, the staff were informed of the identified injury. However the charge nurse, NC, and family were not notified. The evening charge nurse, RPN #123, assessed the resident and found the identified injury on resident #052's on an identified area of the resident's body. Weekly skin assessments were done and a consult was made to the skin lead, which included the above observation.

An interview with PSW #121 indicated after the discovery of the resident's identified injury and allegation, the change nurse was not notified immediately. PSW #121 revealed that they had informed their PSW partner for care PSW #146.

An interview with PSW #146 indicated they were informed by PSW #121 that the resident had a bruise and asked resident #052 how the resident received it and the resident did not know. PSW stated the charge nurse was not notified in the morning because the charge nurse was busy. At approximately 1430 hours, the PSW reported to the charge nurse, RPN #123.

Interview with RPN #123 indicated upon discovery of the resident's identified injury and allegation, the MOHLTC and family were not notified, however during the change of shift report the oncoming shift were informed.

An interview with the DON indicated the PSW staff who discovered resident # 052's injury did not notify the change nurse immediately in the morning when the injury was discovered. The charge nurse was informed by PSW #146 at 1430 hours, after the shift ended, and RPN then reported to the oncoming shift. However, the home's management was not notified and the Director was subsequently not notified. Therefore the home did not make a mandatory report to ensure the home's policy to promote zero tolerance of abuse and neglect was complied with. [s. 20. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 of the following that the licensee knows of, or that was reported to the licensee, was immediately investigated.

CIR #2957-000023-17 submitted to the MOHLTC indicated that on an identified date, resident #008 was noted to have identified injuries and was sent to hospital for an identified medical procedure, but no medical condition was identified from the procedure. The resident continued to have pain in the identified area of the body and the injuries appear to have worsened. The resident was reassessed and a repeated medical procedure was ordered. The results came back four days later which indicated an identified medical condition.

Review of resident #008's RAI-MDS assessment and plan of care indicated the resident had cognitive and physical impairment.

Interview with NC #120 revealed they were away for an identified period after the incident. When NC #120 returned, they were told by the identified family member that resident #008 pointed at a staff member and indicated the staff caused the resident the pain. NC #120 indicated the family suspected an abuse had happened to the resident and NC #120 told the family member that they will look into this.
NC #120 further stated that as they thought the cause of the identified injury was previously investigated, they did not investigate the suspicion of the abuse. NC #120 also

stated they had no recollection of any investigation to resident #008's identified injury.

Interview with the AGM indicated the home's expectation is when someone has reasonable grounds to believe an abuse had happened to a resident and reported the suspicion to one of the leadership team members, the team member should immediately report the suspicion to the Director and investigate the suspicion. The AGM confirmed that the home failed to investigate the suspicion of abuse towards resident #008 as required. [s. 23. (1) (a)]

2. Review of a complaint submitted to the MOHLTC on an identified date indicated that a week prior, the resident alleged that they were told by staff to wait when they asked the staff for assistance at 0930 hours to be changed after an incontinence episode. The PSW returned at 1200 hours and the resident requested again to be changed, the staff told them to wait until after lunch and then brought the resident to the dining room with soiled continence care product. After lunch the resident was brought back to their room and left to wait until 1330 hours when they were provided assistance in changing their continence care product.

In an interview, NC #120 stated that resident #042 had asked how long the staff break was, and NC #120 replied 30 minutes. The resident then stated that on an earlier identified date, at 0930 hours they wanted to be changed and staff were not available. At 1045 hours, PSW #150 approached and told them that they will come back. The PSW return just before lunch and told the resident that they will assist them after lunch and brought them in the dining room. The resident said the staff toileted them at 1330 hours. NC #120 stated that the resident felt bad and was upset.

NC #120 stated that PSW #150 had provided care to resident #042 at least once since the incident occurred, and confirmed that they had not initiated a home's investigation at the time of inspection, which was 22 days later.

In an interview AGM #151 acknowledged that home investigation had not been initiated. They indicated that the home's expectation was to initiate an internal investigation immediately once the NC became aware of the alleged neglect. [s. 23. (1) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that (a) a care conference of the interdisciplinary team providing a resident's care was held at least annually to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker; (b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct were given an opportunity to participate fully in the conferences; and (c) a record was kept of the date, the participants and the results of the conferences.

A complaint was received by the MOHLTC regarding care conferences. On the complaint, the family member stated that there were no care conferences held regarding resident #021 and POA was never updated about change of status. In an interview, the resident's family member identified that they had not been invited to the annual care conference for resident #021 in a few years.

A record review of the resident progress note documentation on care conferences revealed that there was only one care conferences held since the resident was admitted an identified number of years ago. The home's policy called "Care Conferences (Admission & Annual)", number 04-18, identified that care conferences to be held six weeks after admission, then annually and when residents' condition changes. The Administrative Assistant would book the Care Conference and notify the multidisciplinary team once the date and time were confirmed. The policy also directed staff to record the details discussed at the Care Conference as "Care Conference Progress Note" in the current computerized software system.

The Administrative Assistant was interviewed, they identified they were new to the home and was not able to find records of care conferences except the abovementioned one. The AGM was interviewed and identified that the NC was responsible for coordinating and scheduling the annual care conference for the resident. NC #125 was interviewed and they were unable to locate any documentation for two previous years, and indicated that care conferences were not done for resident #021 in those two years. The AGM was interviewed and also confirmed the care conferences for resident #021 for the two identified years prior were not done. [s. 27. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident receive preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Observations of resident #051's feet on two identified dates indicated the resident's toe nails to be long and required trimming.

The written plan of care on an identified date indicated the registered team member to trim the nails of residents with an identified medical condition.

A review of the log books for nail care did not show any nail requests or appointments had been made for the nail care for resident #051.

A review of the progress notes for nail care for an identified number of months indicated only one entry on an identified date noting a toe nail was too long to cut. No other nail related entries were found.

An interview with RPN #119 indicated the RPN would trim the fingernails of residents with an identified diagnosis and a nail consultant would be requested to trim the toe nails. No entries or requests were made in this log for resident #015. RPN #119 confirmed resident #051's toe nails were long and required trimming.

Interview with the DON confirmed the nails of residents are to be trimmed and in this instance, basic foot care services were not provided. [s. 35. (1)]

2. The licensee has failed to ensure that the residents receive fingernail care, including the cutting of fingernails.

Observations of the resident #051's hands on three identified dates showed that the resident's fingernails were long and required trimming.

The written plan of care on an identified date indicated registered team members to trim the nails of residents with an identified medical condition.

An interview with RPN #119 revealed the RPN would trim the fingernails of residents with the identified diagnosis. An interview with RPN #113 indicated the RPN is responsible for trimming the nails of residents with the identified diagnosis and following visualization of the resident's hands, confirmed resident #051 required nail trimming.

An interview with the DON confirmed the nails of residents are to be trimmed and in this instance, basic finger nail care had not been provided. [s. 35. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The license has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

This inspection for skin and wound care was initiated for resident #006 related an identified alteration in skin integrity.

Review of resident #006's Skin Observation Tool on an identified date indicated that the resident was admitted with an alteration in skin integrity.

Review of the home's policy titled, "Skin and Wound Care Program" in Tab 04-78, Nursing Manual, Care section, revealed:
The registered team member will conduct an assessment and document that assessment when there is a change in skin integrity and weekly thereafter until it is healed.

Review of the weekly Skin Observation Tool indicated there were no weekly Skin Observation Tools completed for three weeks after the resident was admitted, and the next Skin Observation Tool was completed on the fourth week.

Interview with RPN #141 revealed that there was no weekly skin assessment done for the resident for three weeks after the initial assessment, and that it should have been done weekly since admission, as the resident was admitted with altered skin integrity.

Interview with NC #120 and the Skin and Wound Lead/RAI Coordinator #139 revealed that it was the home's expectation for the registered staff to complete a weekly skin assessment for resident #006 starting at the time of admission, as the resident was admitted with altered skin integrity, and that this was not done for resident #006 for the four weeks after the resident's admission.
Interview with the AGM revealed that resident #006's identified alteration in skin integrity had not been reassessed at least weekly by a member of the registered nursing staff for four weeks after resident #006 was admitted. [s. 50. (2) (b) (iv)]

WN #13: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

Review of a complaint submitted to the MOHLTC on an identified date indicated that a week prior, the resident alleged that they were told by staff to wait when they asked the staff for assistance at 0930 hours to be changed after an incontinence episode. The PSW returned at 1200 hours and the resident requested again to be changed, the staff told them to wait until after lunch and then brought the resident to the dining room with soiled continence care product. After lunch the resident was brought back to their room and left to wait until 1330 hours when they were provided assistance in changing their continence care product.

According to the RAI-MDS assessment and the resident's written plan of care, resident #042 was incontinent and will tell staff when they want to be changed, and they required an identified level of assistance with a specified number of staff to assist with this care.

Review of the resident's continence assessment on two identified dates indicated the identification of causal factors, and potential to restore function with specific interventions were not included.

In interviews RN #168 and ADON #164 stated that resident #042's continence assessment was not completed as it did not include causal factors, and potential to restore function with specific interventions. [s. 51. (2) (a)]

2. Review of resident #041's written plan of care on an identified date under bladder and bowel function indicated the resident was at an identified level of continence for bladder and bowels. The resident requires an identified level of assistance and a specified number of staff to assist the resident with continence care. Review of the continence assessment record on PCC and resident's paper chart had not identified any completed continence assessment since admission.

Interviews with RN #168 and ADON #164 confirmed that resident #041's continence assessment was not completed. [s. 51. (2) (a)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 5th day of September, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	IVY LAM (646), DEREGE GEDA (645), JUDITH HART (513), JULIENNE NGONLOGA (502), MATTHEW CHIU (565)
Inspection No. / No de l'inspection :	2018_484646_0004
Log No. / No de registre :	004736-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 5, 2018
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Humber Heights 2245 Lawrence Avenue West, ETOBICOKE, ON, M9P-3W3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pauline Dell'Oso

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 36.

Specifically the licensee must:
1) Ensure the safe use of transferring devices or techniques are provided for residents #008, #041 and any other residents are based on the residents' assessed care needs.

2) Ensure direct care staff assisting residents #008, #041 and any other residents, are aware of the safe use of transferring devices or techniques prior to providing transfer assistance for the residents.

Grounds / Motifs :

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

Review of Critical Incident System (CIS) Report #2957-000033-17, submitted on an identified date, and review of a complaint submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a subsequent identified date, indicated that resident #041 reported to an identified staff that a team member was rough with them during care. The resident complained of pain on an identified area of their body and upon assessment an identified alteration in skin integrity was noted.

Review of Resident Assessment Instrument - Minimum Data Set (RAI-MDS) on an identified date, revealed that resident #041 had modified independence in making decision. The resident also had identified physical limitations.

Review of progress notes indicated that on the identified date of the CIS report

submission, an alteration in skin integrity was noted on one identified area of resident #041's body, and two other alterations in skin integrity were identified on another identified part of the resident's body. The resident told staff the identified alterations in skin integrity was caused by the staff who worked on an identified shift, and the resident stated they had a lot of pain. When asked what led to the incident, the resident told the staff it was when they called somebody to put them in bed.

Review of the written care plan indicated that resident #041 required two team members for the identified care.

Personal Support Worker (PSW) #152 no longer worked at the home at the time of the incident and was not able to be interviewed.

According to the home's investigation notes, PSW #152 had said that on the identified date of the incident, resident #041 called for assistance, and PSW #152 went to assist the resident and found them sitting on the floor of their room. The resident had stood up without assistance and the PSW proceeded to bring the resident to the washroom but the resident did not want to go and was upset. PSW #152 told the resident they needed to change the bed. PSW #152 took the resident to the washroom with an assistive mobility device and brought the resident back to bed.

In an interview, Neighbourhood Coordinator (NC) #120 confirmed that PSW #152 had toileted the resident without assistance and without the specific identified assistive device on the date of the incident, which resulted in the alteration of skin integrity to the identified part of the resident's body.

According to NC #120, and the Assistant General Manager (AGM), PSW #152 was no longer working in the home as a result of this incident, among other reasons. (502)

2. CIS report #2957-000009-18 submitted to the MOHLTC indicated that on an identified date, when resident #008 was being transferred, the resident made a lot of physical movements in an identified mobility device while staff were adjusting an identified assistive device for the resident. The resident sustained an identified injury which required the resident to be sent to the hospital.

Review of resident #008's RAI-MDS assessment and plan of care revealed the

resident required an identified assistive device for transfer.

Review of the home's incident report on an identified date indicated at an identified time, PSWs #121 and #122 were transferring resident #008 with the identified assistive device and the resident sustained an injury of an identified size and was sent to the hospital.

Review of progress notes from an identified period of time showed that the resident had been resistive to care on four separate dates. The resident was reassessed by Kinesiologist (KIN) #124 for transfer on an identified date, and indicated using a specified assistive device. Further review of the progress notes indicated the resident was still resistive on three other identified dates prior to the above reported incident on the identified date.

Interview with PSW #121 and #122 indicated that PSW #121 provided the morning care to resident #008 on the identified date, and the resident was resistive during care. After calming the resident, PSW #121 and #122 proceeded with the care activity. PSW #121 stated that the resident became resistive to care, and after calming the resident again, the two PSWs continued to proceed with the care. Both PSW's stated that the resident did not resist care again until they were seated in the specified device. The resident became resistive and hit the device causing it to rebound and hit the resident resulting in an injury.

Interviews with KIN #124, PT #114, and NC #120 indicated a safe technique for using the identified assistive device includes staff to ensure that a resident is not resistive to the identified care before it starts. If the resident is resistive to the identified care, staff should stop and reapproach the resident at another time. If the resident is calm and not resistive later, staff can initiate the identified care using the identified assistive device. PT #114 and NC #120 indicated a post-incident huddle was conducted on the date of the above-mentioned incident. During that time, it was reported that the resident was resistive to the care, and the PSWs did not leave the resident and reapproach the resident at another time in order to make sure the resident was calm and not resistive.

NC #120 confirmed that on the identified date, the home failed to ensure that PSW #121 and #122 used safe transferring techniques when assisting resident #008.

The severity of this issue was determined to be a level 3 as there was actual

harm to resident. The scope was a level 1 isolated, as the risk of harm was related to one of the resident living in the home area. The home had a level 4 compliance history as they had on-going non-compliance with this section of the LTCHA that included:
- Voluntary Plan of Correction issued November 19, 2015 (#2015_405189_0019). (565)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 12, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.6(7) of the LTCHA.

Specifically the licensee must:

1) Ensure that resident #037 and any other residents requiring one-to-one (1:1) monitoring intervention in the plan of care is provided with the 1:1 monitoring as specified in the plan.

Grounds / Motifs :

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

This Responsive Behaviours inspection was initiated related to CIS report #2957 -000032-17, related to an incident that occurred between resident #037 and #038 which caused resident #038 to fall. Resident #038 incurred an identified injury to an identified area of their body and was taken to hospital.

Review of resident #037's current plan of care showed that the resident had identified behaviours, with support action including 24hr/7 one-to-one (1:1) companion and required constant supervision. The care plan also revealed that the resident has verbal and physical expression to others related to cognitive impairment/physical changes, and unpredictable situations/without provocation.

Review of resident's progress notes on an identified date showed that the resident had an order for 1:1 monitoring to begin. Review of resident #037's 1:1 schedule records revealed that resident #037's 1:1 monitoring was adjusted to a specified period of time in the day starting on an identified date. Review of the

one-to-one records revealed that on the date of the above-mentioned incident, resident #037 was scheduled to have 1:1 at the same identified period of time.

Interview with PSW #166 revealed that on the day of the incident, PSW #166 was scheduled to work with resident #037, and was doing 1:1 monitoring, when PSW #166 was called by Registered Nurse (RN) #175 to another neighbourhood temporarily for an identified reason. PSW #166 further revealed that they had let the staff on the floor know that PSW #166 had to go downstairs, and then went downstairs. PSW #166 further revealed that they left the neighbourhood without ensuring that there was a staff who would take over the one-to-one monitoring with resident #037.

Interview with Registered Practical Nurse (RPN) #126 revealed that they were aware that RN #175 had requested for PSW #166 to go and assist on another neighbourhood. RPN #126 further revealed that they had told the staff to keep an eye on the resident, but there was no 1:1 staff provided for the resident after PSW #166 left the neighbourhood.

Interview with RN #175 indicated that they had asked PSW #166, who was resident #037's 1:1 staff, to go to another neighbourhood for assistance with an identified issue, and because it was at an identified mealtime, the RN had anticipated that the issue would be resolved by the time resident #037 finished their meal. RN #175 further revealed that resident #037 would have been without the 1:1 between just before meal until just after the incident with resident #038. Review of the CIR revealed that the incident occurred just after the mealtime.

Interviews with NC #125 and Assistant Director of Nursing (ADON) #164 revealed that the 1:1 monitoring for resident #037 is required related to the resident's identified behaviours toward others, and that the resident was not provided with their 1:1 staff as per resident #037's planned care at the time of the incident. Interview with the Acting General Manager (AGM) revealed that resident #037 should have been provided with their one-to-one staff as per the resident's plan of care, and that 1:1 staff should not be removed from the residents whom they have been assigned to.

The severity of this issue was determined to be a level 3 as there was actual

harm to resident. The scope was a level 1 as the risk of harm was related to one of the resident living in the home area. The home had a level 4 compliance history as they had on-going non-compliance with this section of the LTCHA that included:
- Voluntary Plan of Correction issued March 22, 2017 (#2017_637500_0007);
- Voluntary Plan of Correction issued August 12, 2015 (#2015_342611_0010). (646)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 12, 2018

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 5th day of June, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Ivy Lam

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