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
Feb 23, Mar 1, 2018	2018_448155_0001	029094-17	Resident Quality Inspection

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Fergus Nursing Home
450 Queen Street East FERGUS ON N1M 2Y7

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

SHARON PERRY (155), ALI NASSER (523), JANETM EVANS (659), MARIAN MACDONALD (137), NUZHAT UDDIN (532)

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): January 8-12, 15-19, 22-26, and 29-31, 2018.

The following intakes were completed within the RQI:

Follow-up to a Director's Orders issued by the Director as a result of a follow up inspection done by Inspector #137, # 2017-508137-0018 which resulted in a Director Referral.

Director Order (DO) #001 LTCHA, 2007 S.O. c.8 s. 15. (2) has been complied with.

Follow up:
Log 023314-17 follow-up to CO#001, inspection # 2017_508137_0018 was related to plan of care,
Log 023317-17 follow-up to CO#002, inspection # 2017_508137_0018 was related to cleanliness and maintenance of the home,
Log 023340-17 follow-up to CO#003, inspection # 2017_508137_0018 was related to abuse and neglect,
Log 012341-17 follow-up to CO#004, inspection # 2017_508137_0018 was related to responsive behaviours, and
Log 023343-17 follow-up to CO#005, inspection # 2017_508137_0018 was related to responsive behaviours.

Complaints:
Log 002802-17 was related to lack of continence supplies,
Log 026468-17 was related to care and assessment of resident,
Log 023681-17 was related to alleged resident to resident abuse, and
Log 023428-17 was related to not following residents' plan of care.

Critical Incident System (CIS):
-Log 005196-17, CIS 2603-000015-1; Log 014367-17, CIS 2603-000030-17; Log 024749-17, Log 024755-17, CIS 2603-000041-17; CIS 2603-000042-17; Log 013755-17, CIS 2603-000029-17; Log 002786-17, CIS 2603-000007-17; Log 001795-18, CIS 2603-000011-18 were related to alleged staff to resident abuse.
-Log 023459-17, CIS 2603-000040-17 related to alleged resident to resident abuse.
-Log 031499-16, CIS 2603-000038-16 related to alleged improper/incompetent treatment resulting in injury.
-Log 010650-17, CIS 2603-000025-17; Log 005249-17, CIS 2603-000014-17; Log 028698-17, CIS 2603-000046-17; Log 028566-17, CIS 2603-000044-17; Log 000481-18, CIS 2603-000001-18 were related to incidents in which residents were taken to hospital with a significant change in condition.
-Log 021183-17, CIS 2603-000035-17 related to outbreak.
-Log 012652-17, CIS 2603-000028-17 related to missing resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing, Resident Care Coordinator, Resident Assessment Instrument (RAI) Coordinator, Nutrition Manager, Activity Coordinator, Physician, Pharmacist,

Registered Dietitian, Regional Manager, Independent Consultant, Maintenance Worker, Nurse Clerks, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers, Housekeepers, Resident Council representative, Family Council representative, residents and their families.

The inspectors also toured the home, observed meal service, medication administration medication storage; reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, posting of required information, home's investigation notes, employee files; observed the provision of resident care, resident-staff interactions, and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #002	2017_508137_0018	137
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #003	2017_508137_0018	523
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #001	2017_508137_0018	523

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. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (4) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section,
(a) has at least one year of experience working as a registered nurse in the long-term care sector; O. Reg. 79/10, s. 213 (4).
(b) has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and O. Reg. 79/10, s. 213 (4).
(c) has demonstrated leadership and communication skills. O. Reg. 79/10, s. 213 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section,
(a) had at least one year of experience working as a registered nurse in the long-term care sector;
(b) had at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and
(c) had demonstrated leadership and communication skills.

On February 8, 2018 Inspector #155 called the home and spoke with Administrator #102. They shared that the Director of Nursing #103 had not returned to work after January 31, 2018 when the inspectors left the home and that the DON's last day was February 9, 2018. Inspector #155 asked that the home submit a plan by e-mail regarding Director of Nursing coverage in the home. On February 12, 2018, Inspector #155 received an email from Administrator #102 stating that RN #134 will be covering most of the critical duties of the Director of Nursing while being supported by Independent Consultant #152, corporate supports and by the Resident Care Coordinator #121 who was in the home five days per week.

After receiving the email on February 12, 2018, Inspector #155 phoned the home and spoke with Administrator #102 and asked them to explain how their plan met the Long Term Care Homes Act and Regulations. Administrator #102 said that they were unsure and would look into it. On February 13, 2018 Administrator #102 called Inspector #155 and told them that RN #134 was a Registered Nurse but did not have three years of experience working as a registered nurse in a managerial or supervisory capacity in a

health care setting. Inspector #155 again asked Administrator #102 to provide an update by email of how their plan met the Long Term Care Homes Act and Regulations along with RN #134's resume and credentials.

On February 14, 2018, Inspector #155 received an email from Administrator #102 with their explanation of their plan and RN #134's resume and credentials. The email states that they attached the resume and credentials for RN #134. The email also stated that RN #134 did not meet the requirement of having three years managerial experience in a supervisory role within a long term care facility "as recommended" in Long Term Care regulations. They stated that they are actively in the process of recruiting a new Director of Nursing.

RN #134 did not meet the legislative requirements for the Director of Nursing and Personal Care.

The licensee failed to ensure that the long-term care home had a Director of Nursing and Personal Care that had the following:
(a) At least one year of experience working as a registered nurse in the long-term care sector;
(b) At least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and
(c) Had demonstrated leadership and communication skills.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a level 3 as it had the potential to affect all residents in the home. Compliance history was a level 2 as there was one or more unrelated non-compliance in the last 36 months. [s. 213. (4)]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident were identified, where possible;
(b) strategies were developed and implemented to respond to these behaviours, where possible; and
(c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the residents responses to interventions were documented.

Compliance Order # 004 was issued on September 13, 2017 with a compliance date of October 31, 2017, following a Follow up Inspection. The Compliance Order stated that "The licensee shall ensure there is a process developed and implemented for all residents demonstrating responsive behaviours to ensure strategies have been developed and implemented to respond to the residents' responsive behaviours. The process shall include staff roles and responsibilities including which staff are responsible for monitoring the implementation of the strategies".

(A) A clinical record review over a period of time, showed resident #029 exhibited several responsive behaviours. The resident's plan of care showed there was only one type of responsive behaviour identified and there was no documented evidence of the other types of responsive behaviours on the plan of care.

Resident #029 had not been assessed, interventions were not developed and implemented to manage the behaviours and there were no procedures or interventions

developed and implemented to assist residents/staff who were at risk of harm or were harmed as a result of the resident's responsive behaviours. Risk management reports were not completed. Despite exhibiting responsive behaviours for almost a year, a Behavioural Support Ontario (BSO) referral was not made for the resident until inspectors were in the home.

During an interview with the Registered Nurse - Resident Assessment Instrument (RN - RAI) Coordinator #105, Inspector #137 reviewed the responsive behaviours and the plan of care for the resident. RN - RAI Coordinator #105 said resident #029 definitely had significant behaviours that were not identified on the care plan but should be, resident #029 should have been assessed and a BSO referral should have been made long before now.

During an interview with Registered Nurse - Resident Care Coordinator (RN RCC) #121, Inspector #137 reviewed the responsive behaviours and plan of care for resident #029. RN - RCC #121 said resident #029 certainly had responsive behaviours which were not identified on the care plan, there were no Risk Management reports completed and a referral should have been made to BSO a long time ago.

During an interview on January 23, 2018, BSO - Personal Support Worker #123 (PSW) said resident #029 had behaviours that resulted mainly from a specific trigger however, BSO PSWs had nothing to do with the care plans. BSO PSWs were not allowed to chart in Point Click Care (PCC) so they created a word document and placed it in the BSO binder. The BSO - RPN then entered the notes in PCC, with their signature.

(B) During an interview Inspector #137 asked Behavioural Support Ontario - Registered Practical Nurse (BSO - RPN) #136 if a process had been developed and implemented for all residents demonstrating responsive behaviours to ensure strategies have been developed and implemented to respond to the residents' responsive behaviours, including staff roles and responsibilities, as well as who was responsible for monitoring the implementation of the strategies. BSO - RPN #136 said there was no formal process in place, what was there was disorganized and Director of Nursing (DON) #103 was responsible for overseeing the BSO team but they were not receptive or supportive to ideas and suggestions offered by the BSO team. The Psychogeriatric Resource Consultant (PRC) made two attempts to meet with DON #103 to discuss their concerns but was unsuccessful.

BSO - RPN #136 said a Psychogeriatric Resource Consultant (PRC) visited the home,

approximately three to four times a year and as needed, if requested. The PRC provided the assessment tools used by the home which were kept in a BSO binder for the BSO team to access. Referral forms to the BSO team were available at the central nurses' desk for nursing staff to complete but the folder was usually empty. BSO - RPN #136 said they were familiar with what was expected of them but there was currently no formal process in place that outlined the role and responsibilities of the BSO - RPN or BSO - PSWs and no process that identified who was responsible for monitoring the implementation strategies related to responsive behaviours.

During an interview with Regional Manager #143 and External Consultant #152, the External Consultant said that the current responsive behaviour program needed much work. That was the next program that they will be working on starting in February 2018. As the DON was leaving, there was no one from management overseeing the BSO program currently. It was undetermined as to who was going to take that over, whether a new DON or RCC.

The licensee failed to ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident were identified, where possible;
(b) strategies were developed and implemented to respond to these behaviours, where possible; and
(c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented. [s. 53. (4)] (137)

2. The licensee has failed to ensure that strategies were developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Review of the Critical Incident System (CIS) indicated that resident #080 was observed by a Personal Support Worker (PSW) exhibiting responsive behaviours. As a result of the incident, resident #080 was placed on a specific intervention and the Pharmacist was asked to complete a medication review for the resident. A record review of the specific intervention was done with MDS/RAI Coordinator #105 and it was noted that the specific interventions were documented in bulk at the end of the shift and not at the scheduled times. MDS/RAI Coordinator # 105 was interviewed and they said that it was difficult to determine if the interventions were actually done at the scheduled times as they were documented all at the end of the shift (in bulk) or if the interventions were done at all.

A progress note indicated that the Nurse Practitioner discussed a proposed switch in medication with resident #080's Power of Attorney (POA). Consent from POA to change medication was not obtained and no changes to current medications was made. NP recommended continuing with the specific intervention, continue to provide and implement non pharmacological approaches.

On eight separate occasions, staff observed resident #080 exhibiting a responsive behaviour. Plan of care for resident #080 indicated that resident had responsive behaviours.
Point of Care (POC) documentation was reviewed and it stated to ensure that resident had no responsive behaviours and a specific intervention was to be completed two times a shift.

BSO RPN #136 and BSO PSW #123 were interviewed regarding resident #080 and the responsive behaviours. BSO RPN #136 went through the progress notes and shared that the resident was on the BSO caseload, they had developed a plan of care for the resident to indicate that the resident had behaviours. BSO RPN #136 explained that more could be done to prevent the incidents. The BSO RPN #136 said they had considered a possible strategy for the resident but this was never implemented. They also indicated that staff required more education in this area of behaviours. They indicated that each manager in the home had provided different direction in terms of how to address the responsive behaviours. They indicated that there was confusion on how to address this responsive behaviour but more strategies could be developed to address the responsive behaviour.

The licensee has failed to ensure that strategies were developed and implemented to respond to resident #080's responsive behaviours.

The severity of this issue was determined to be a level 3 as there was actual harm or risk to the residents. The scope of the issue was a level 2 (pattern). Compliance history was a level 5 as there are multiple non-compliances with at least one related order that included:
Written Notification and a Compliance Order on August 4, 2016, under Inspection # 2016_325568_0015, during a Resident Quality Inspection (RQI);
Written Notification and a Compliance Order on February 24, 2017, under Inspection # 2016_262523_0038, during a Follow up Inspection; and
Written Notification and a Compliance Order on September 13, 2017, under Inspection # 2017_508137_0018, during a Follow up Inspection. [s. 53. (4) (b)] (532)

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that, (a) procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff were advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours posed a potential risk to the resident or others.

Compliance Order #005 was issued on September 13, 2017 with a compliance date of October 31, 2017, following a Follow up Inspection. The Compliance Order stated that "The licensee shall ensure that procedures and interventions are developed and

implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident’s behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents".

(A) A clinical record review over a period of time, showed resident #029 exhibited responsive behaviours. There was only one type of responsive behaviour identified and there was no documented evidence of the other types of responsive behaviours on the plan of care for resident #029. Resident #029 had not been assessed, interventions were not developed and implemented to manage the behaviours and there were no procedures or interventions developed and implemented to assist residents and staff who were at risk of harm or were harmed as a result of the resident's responsive behaviours. Risk management reports were not completed. Despite exhibiting responsive behaviours for almost a year, a Behavioural Support Ontario (BSO) referral was not made for the resident until inspectors were in the home.

During an interview Behavioural Support Ontario - Registered Practical Nurse (BSO - RPN) #136 said there was no formal process in place and what was there was disorganized. Mandatory huddles were started shortly after the last Ministry of Health (MOH) visit. The huddles took place twice a day, including week-ends, and all departments attend. Behaviours were included in the discussion. BSO - RPN #136 said a new Responsive Behaviour policy and procedure was developed in September 2017 by Registered Nurse - Resident Assessment Instrument Coordinator (RN - RAI) #105 and Director of Nursing (DON) #103, after the last MOH visit. The policy was sent for review to Head Office, then to the Psychogeriatric Resource Consultant (PRC) and now the External Consultant #152 had it. The policy had not yet been implemented. BSO-RPN #136 said that procedures and interventions had not been developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident’s behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

During an interview with Regional Manager #143 and External Consultant #152, the External Consultant said that the current responsive behaviour program needed much work. That was the next program that they will be working on starting in February 2018. As the DON was leaving, there was no one from management overseeing the BSO program currently. It was undetermined as to who was going to take that over, whether a new DON or RCC.

The licensee failed to ensure that,

(a) procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff were advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours posed a potential risk to the resident or others.

The severity of this issue was determined to be a level 3 as there was actual harm or risk to the residents. The scope of the issue was a level 1 (isolated). Compliance history was a level 5 as there are multiple non-compliances with at least one related order that included:
Written Notification and a Compliance Order on August 4, 2016, under Inspection # 2016_325568_0015, during a Resident Quality Inspection;
Written Notification and a Compliance Order on February 24, 2017, under Inspection # 2016_262523_0038, during a Follow up Inspection; and
Written Notification and a Compliance Order on September 13, 2017, under Inspection # 2017_508137_0018, during a Follow up Inspection. [s. 55.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC), which identified that resident #058 had a fall that resulted in injury. On a specific date, PSW #125 and PSW #110 told inspector #523 that the resident was at risk for falls. They said that the resident had a specific safety intervention in place.

Resident observations showed resident #058 with a different intervention in place. On a specific date, RN #115 told inspector that the resident had a specific safety intervention in place and this would be reflected in the plan of care. RN #115 completed an observation with inspector and acknowledged that the resident had a different intervention in place. RN #115 reviewed the care plan and the Kardex in Point of Care and said that the intervention and direction given to the staff was not clear on what intervention to use. RN #115 said that intervention should provide clear direction for the staff on what type of intervention to use. RN #115 said that this does not provide clear direction to the staff on what type of intervention to be used.

On a specific date, PSW #110 told inspector #523 and RN #115 that the resident had a specific safety intervention that should be in place. PSW, RN and inspector completed observation and acknowledged that the resident had a different intervention in place. PSW #110 said that they were not aware that the resident had this intervention.

On a specific date, RN RAI Coordinator #105 reviewed the plan of care with inspector and acknowledged that there was no clear direction given to staff on what type of intervention to use. RN #105 told inspector that they would assess the resident and ensure the correct intervention was in place and that would be reflected in the plan of care.

The licensee has failed to ensure that the plan of care set out clear direction for staff and others who provide direct care to the resident. [s. 6. (1) (c)] (523)

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

The Ministry of Health and Long-Term Care received a complaint, where complainant said that resident #059 did not receive a meal. A clinical record review for resident #059 showed that upon admission a progress note showed that the resident required a specific process for their meals. The process would be provided to the resident because of certain circumstances and the resident would continue until a certain time.

In an interview RN #115 said that the resident still required this process. RN said that the intervention would have to be in the plan of care. RN #115 reviewed the plan of care and found no information regarding this. RN #115 acknowledged that the plan of care for the resident did not provide clear direction to staff or others providing direct care to the resident regarding this specific process. [s. 6. (1) (c)] (523)

3. The licensee failed to ensure that there was a written plan of care that set out clear directions to staff and others who provided direct care to the resident.

During stage one of the Resident Quality Inspection resident #008 expressed concerns regarding the toileting care for resident #009. Resident #008 shared that at time the resident was just left without care being provided.

On a specific date, resident #008 shared that resident #009 needed encouragement to get up and that staff need to assist resident #009 with care for toileting, hygiene and dressing. They shared that some PSWs come in and they speak to the resident however, they are not able to understand the PSW and they just leave not giving the encouragement or assistance that the resident needs.

On a specific date, during an interview with PSW #106 they shared that resident #009 required encouragement and prompting to go to the bathroom every two hours as they were incontinent, but with prompting remains dry some of the time. Staff needed to check and assist the resident.

During an interview with PSW #154 they shared resident #009 needed to be encouraged to get up in the morning, they need to be taken to the bathroom and staff need to say with them while cares were done. Resident #009 would assist with their own care but staff needed to stay with them and assist them to ensure that care was done.

Review of resident #009's care plan identified that the resident required extensive assistance with toileting, dressing and personal hygiene. On a specific date PSW #106 viewed resident #009's care plan with Inspector #155. They agreed that there was no

clear direction as to when to toilet resident #009 and that they need to be toileted every two hours. PSW #106 said that new staff would only know to toilet the resident if they were told by them, another staff.

On a specific date, Administrator #102 shared with Inspector #155 and #137 that resident #009 had deteriorated in the last few months and some of the PSWs may have taken for granted that the resident can do more than they can. Administrator #102 shared that resident #008 had expressed that resident #009 needed more cueing and had expressed concerns that some of the PSWs did not know the care that the resident needed.

The written plan of care for resident #009 did not provide clear direction to staff and others who provided direct care to the resident. [s. 6. (1) (c)] (155)

4. The licensee has failed to ensure that the plan of care had set out clear directions to staff and others who provided direct care to the resident.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to resident #067 sustaining a fall with injury and required transfer to hospital for assessment.

A review of the plan of care showed the resident had certain functions with mobility however, the Minimum Data Set (MDS) Assessment indicated different functions with mobility.
During an interview Director of Nursing (DON) #103 said that there was a discrepancy and the plan of care did not provide clear direction to staff. During an interview, Resident Assessment Instrument (RAI) Coordinator #105 said that the care plan was ambiguous and did not give clear direction to staff, related to mobility.

The licensee has failed to ensure that the plan of care had set out clear directions to staff and others who provided direct care to the resident.

The severity of this issue was determined to be a level 3 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a level 2 (pattern). The compliance history was a 3 (one or more related non-compliances in the last 36 months). The related non-compliance with this section of the LTCHA that included: Written notification (WN) and voluntary plan of correction (VPC) issued August 18, 2015 (2015_448155_0020). [s. 6. (1) (c)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. What the licensee has done to resolve the complaint, or
ii. That the licensee believes the complaint to be unfounded and the reasons for the belief.

On a specific date resident #008 shared with Inspector #155 that they felt things were getting worse resident #009 was not getting the help with care that they needed and on a specific date resident #009 did not get the care they needed.

Registered Nurse #115 shared that on the specific day, resident #008 did speak to them and Administrator #102 in the Director of Nursing office. RN #115 shared that on that date, resident #008 was upset because it was late morning and resident #009 was still in bed and had not received care. A PSW was directed to get resident #009 up however, continence care and assistance with hygiene and dressing was not provided despite the resident being incontinent.

Administrator #102 shared with Inspector #137 and #155 that on the specific date, they did meet with resident #008 and RN #115 in the Director of Nursing office. Administrator #102 shared that resident #008 had concerns as they felt resident #009 was not getting the care they needed. Administrator #102 stated that some of the PSWs may have taken for granted that resident #009 could do more for themself than they really could. Administrator #102 shared that resident #008 had concerns that the PSWs did not know the care that was needed.

On a specific date, when Inspector #155 asked the Administrator what investigation was done in regards to resident #008's complaint regarding the care of resident #009 they shared that they spoke to RN #115 to address the PSWs. Inspector #155 asked the Administrator if they had followed up with resident #008 about the complaint and Administrator #102 shared that they had not.

Resident #008 shared that Administrator #102 and no other staff had spoken to them about the complaint about resident #009's care.

The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. [s.
101. (1)] (155)

2. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating, i. What the licensee has done to resolve the complaint, or ii. That the licensee believes the complaint to be unfounded and the reasons for the belief.

RN #115 shared with Inspector #155 that some of the Personal Support Workers that worked the past weekend had complained to them that some of the newly hired Personal Support Workers were using brown paper towels that were in the washroom to wash the residents. RN #115 said that they wrote these complaints down and handed them into the Resident Care Coordinator #121. RN #115 provided Inspector #155 with copies of what they had handed into the Resident Care Coordinator #121.

Review of the copies provided to Inspector #155 stated that on a specific date, PSW #162 reported that during their shift that the care carts that were used on days still had towels and washcloths on them. One cart was totally stocked, and the other two carts had more than half the number of towels and facecloths on them. PSW #151 reported that some of the new staff were using the brown paper towels that were in the bathrooms to wash the residents.

Review of copies provided to Inspector #155 stated that on another date, PSW #162 and #151 showed RN #115 the care carts. Cart #1 had four towel sets, cart #2 had 12 towel

sets and cart #3 had 10 towel sets. Evening PSWs said that there should be less towel sets on cart #2 and #3 as they come up to floor stocked with 12 towel sets. RN #115 shared concerns that residents were not being washed properly.

Resident Care Coordinator #121 told inspector #155 that they gave these complaints to Independent Consultant #152 and Regional Manager #143 to give to the Administrator on a certain date.
PSW #151 shared that no one had followed up with them regarding the care issues they shared with RN #115.

Inspector #155 asked Administrator #102 if they were aware of these written complaints completed by RN #115. Administrator #102 said yes, I found those on my desk, I don't know if those were complaints, I spoke with RN #115 and those were their notes. Administrator #102 stated that they suspected that the DON #103 had dealt with these issues.

Administrator #102 was not able to provide any record of investigation or follow up done.

The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. [s.101. (1)] (155)

3. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

A) A Spills Action Centre (SAC) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) and a Critical Incident System (CIS) report was submitted.

On a specific date an incident occurred involving a PSW and a resident not receiving care. RN #115 directed PSWs #126 and #154 to provide the specific care to the resident, which they did. RN #115 reported the incident to Resident Care Coordinator (RCC) # 121. RCC #121 reported the concern on a specific date by email, to the Director of Nursing, Administrator, Regional Manager and external Nursing Consultant. Administrator #102 met with PSW #141 the following morning. PSW #141 denied the allegation. The Administrator felt satisfied with the explanation provided by PSW #141. There was no documented evidence that any interviews or follow-up investigation was completed with RN #115, RCC #121 and PSWs # 126 and # 154.

During interviews RN #115 and RCC #121 said they had not been interviewed related to the incident.

During an interview Administrator #102 said they could have done a better job of the follow-up investigation with the incident involving resident #029.

During an interview, RN #115 said there were concerns related to the provision of care by some recently hired PSWs. There was an incident on a specific date involving a specific care a PSW was providing a resident. RN #115 intervened and requested the resident be removed from the situation. RN #115 requested for another PSW to assist. Resident #012 was removed from the situation but PSW #141 did not know how to perform a function of the task and had to be shown how to complete the task. RN #115 reported the incident to the RCC #121 who sent an email to Director of Nursing (DON) #103 and Administrator #102 on a specific date informing them of the incident and suggested that PSW #141 may need education related to this task.

During an interview Inspector #137 asked DON #103 if there was an investigation related to the incident. DON #103 said that they only found out about the incident when they received an email from RCC #121 at a later date. Inspector #137 showed DON #103 an email that was sent by RCC #121 on the date of the incident, to the DON and Administrator, informing them of the incident. DON #103 said that they were behind in reading their emails. Inspector # 137 said the incident took place almost three weeks ago and, to date, there was no investigation initiated.

During an interview Inspector #137 told DON #103 and Administrator #102 that some staff had told the Inspectors that they bring written concerns forward to management but they are not dealt with.

A review of employee files showed PSW #141 had not been provided orientation for the task used while providing specific care. During an interview, Administrator #102 said that they noticed PSW #141 had not been provided orientation and would not be assigned to that care task until they were orientated. Administrator #102 said that they now started the investigation into the incident and planned to meet with PSW #141 when the DON was available. On the last day of the inspection, Administrator #102 said the interview with PSW #141 would be delayed as DON #103 was not present at the home.

The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

The severity of this issue was determined to be a level 3 as there was actual risk to the residents. The scope of the issue was a level 2 (pattern). The compliance history was a 2 (one or more unrelated non-compliances in the last 36 months). [s. 101. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted:
Every resident had the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

During stage one of the Resident Quality Inspection resident #008 expressed concerns regarding the toileting care for resident #009. Resident #008 shared at times resident #009 was just left without care being provided.

On a specific date, resident #009 shared that resident #008 needed encouragement to get up and to go to the bathroom that staff need to assist resident #008 with care by taking them into the bathroom and to help them provide hygiene, grooming and dressing. They shared that the some PSWs just leave not giving the encouragement or assistance that the resident needs.

RN #115 shared that on a specific day, resident #009 did not receive morning care. As a result the home submitted a Critical Incident Report for alleged staff to resident neglect. RN #115 also shared that on another specified date they were working resident #009 was not provided morning care and was found to be incontinent. On a specific date, Inspector #155 observed resident #009 lying in bed, noting the resident had not been provided morning care and was incontinent. DON #103 observed resident and said that they would have someone come to provide care.

Review of resident #009's most recent Minimum Data Set (MDS) assessment for

resident #009 states that the resident required extensive assistance.

The licensee failed to ensure that resident #009's right to be properly clothed, groomed and cared for in a manner consistent with his or her needs was fully respected and promoted. [s. 3. (1) 4.] (155)

2. The licensee failed to ensure that the rights of residents are fully respected and promoted in that every resident had the right to be told who is responsible for and who was providing the resident's direct care.

On January 31, 2018, Inspector #155 was looking to speak with Personal Support Worker #137. Inspector #155 met two Personal Support Workers walking in the hallway by the north nursing station. Inspector #155 noticed that according to their name tags they both had the same first name. Inspector #155 asked the two PSWs if they knew where Personal Support Worker #137 was. One of Personal Support Workers replied that they were Personal Support Worker #137. Personal Support Worker #137 explained that they were working 1100 hours to 1900 hours on the bath shift and had forgot to bring their name tag so barrowed their coworkers name tag (PSW #126) until they could go home on their break and get their own name tag. After talking with PSW #137 they went back out on the unit without removing the name tag.

The licensee failed to ensure that the rights of residents were fully respected and promoted in that every resident had the right to be told who was responsible for and who was providing the resident's direct care. [s. 3. (1) 7.] (155)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted: every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, and every resident has the right to be told who is responsible for and who is providing the resident's direct care, to be implemented voluntarily.

WN #7: 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 was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

Review of the home's policy Abuse and Neglect, effective February 2017, last reviewed February 2017, documented:
1. All cases of suspected or actual abuse must be reported immediately to the DON/Administrator.
In the absence of management staff, concerns should be reported immediately to the charge nurse, who will notify management staff on call. The reporting person should have the following:
-The name(s) of the resident(s) or staff member(s) to which the abuse or suspected abuse occurred;
-The date and time that the incident occurred
-Where the incident occurred
-The name(s) of any witnesses to the incident
-The type of abuse being reported (i.e. verbal, physical, neglect, etc.) -
Any injuries to resident, staff resulting from the incident.
2. After receiving notice of the abuse, the DON/Manager on call will immediately notify the Administrator of the initiation of an investigation
3. The Administrator may notify Head Office of the investigation to receive direction to assist in deciding how to respond to the incident and/or what HR actions may need to be taken
4. The DON and/or Administrator will provide a supportive environment for the victims, family and employees by allaying fears of reprisal and promoting open expression of the concerns or
questions.

5. The Administrator/DON or delegate shall notify the police immediately of any alleged, suspected or witnessed incident of abuse or neglect that may constitute a criminal offence.
6. The Administrator/DON who has reasonable grounds to suspect that any of the following has occurred or may occur must immediately report that suspicion and the information upon which the suspicion is based to the Director appointed by the Ministry of Health and Long Term Care
a)Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident;
b)Abuse of a resident by anyone, or neglect of a resident by the home or its staff, that resulted in harm or a risk of harm to the resident
c)Unlawful conduct that resulted in harm or a risk of harm to a resident
d)Misuse or misappropriation of a resident's money; or e)Misuse or misappropriation of funding provided to the Home under the Long Term Care Homes Act, 2007.

During stage one interviews, resident # 031 stated that there had been an altercation between the resident and a staff member during care. Resident #031 stated that it happened twice with the same staff member involved. Resident #031 stated they spoke to another staff about the incident and they took notes of the conversation.

Review of the clinical record showed resident #031 required physical assistance with personal care. In interviews Registered Nurse (RN) #115 stated they recalled this incident. RN #115 stated that they saw this as alleged abuse and they spoke to PSW #126 about the incident. RN #115 acknowledged that they had not reported the incident to management and they should have.

In interviews, the Resident Care Coordinator (RCC) #121, Director of Care (DOC) # 103 and Administrator #102 stated they had not been aware of the incident involving resident #031. They stated the expectation was that staff would report the incident and management would do an investigation and submit a Critical Incident Report (CIR).

The licensee had failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)] (659)

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.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 failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee was immediately investigated:

(ii) Neglect of a resident by the licensee or staff.

Registered Nurse #115 shared that resident #008 had expressed concerns regarding the lack ofcare of resident #009. Registered Nurse #115 explained that they wrote the concern on the Report of Complaint form and submitted it to the Resident Care Coordinator #121.

Resident Care Coordinator #121 called the Ministry of Health and Long Term Care after hours pager and reported alleged neglect. At a later date, the home submitted a Critical Incident for alleged staff to resident neglect regarding PSW #138 and resident #009.

Administrator #102 was asked for the investigation notes regarding Critical Incident Report regarding alleged staff to resident neglect. The Administrator #102 stated that they were not aware that a Critical Incident Report had been submitted and would have to look to find the investigation notes as the Director of Nursing was not in.

The licensee failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident by the licensee or staff that the licensee knows of, or that is reported to the licensee was immediately investigated. [s. 23. (1) (a) (ii)] (155)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of neglect of a resident by the licensee or staff, that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #9: 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 licensee has failed to ensure that a person who had reasonable grounds to suspect that financial abuse of a resident by anyone had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

The Inspectors were made aware during the Resident Quality Inspection that an allegation of financial abuse of a resident by staff member was not reported to the Director.

Administrator #102 said that they were made aware of an allegation of staff to resident financial abuse. Administrator #102 said that a staff member informed them of the allegations but it was all rumours. Administrator #102 said that they completed an internal investigation including staff and resident interviews based on the allegation of financial abuse. The staff involved and the resident both denied it. There was no evidence that financial abuse occurred.

Administrator #102 said that based on their findings of the internal investigation they did not report the allegations to the Director. [s. 24. (1) 2.] (523)

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 ensue that a person who has reasonable grounds to suspect that 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 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 #10: 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,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who require continence care products have sufficient changes to remain clean, dry and comfortable.

Plan of care indicated specific directions to provide continence care product changes.

A review of progress notes showed that the continence care products were not sufficient to keep the resident clean, dry and comfortable on multiple dates.

DOC #103 did not think that there was shortage of supplies as the former RCC had ordered supplies for the resident. Review of the progress notes from RCC, RPN and the RN were reviewed with the DOC and the DOC #103 acknowledged that it was possible that there was shortage as it was documented on PCC.

The licensee has failed to ensure that resident #078 who required continence care products had sufficient changes to remain clean, dry and comfortable. [s. 51. (2) (g)] (532)

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 who require continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In an interview the Family Council President said that they did not receive within 10 days a response in writing to their concerns or recommendations.

A review of the Family Council meeting minutes for the months of October, November and December were done and showed that for three consecutive months in 2017 the Administrator did not respond in writing within 10 days.

In an interview the Activity Director #108 said that they were aware that the responses to the Family Council concerns or recommendations were not being completed within 10 days, they acknowledged that the responses were late and said that they will continue to work with the management team to ensure the responses were completed within 10 days.

Administrator #102 said that they did not respond within 10 days of the council raising their concerns. Administrator said that they would work with the team to review the process to ensure responses were being completed within 10 days.

The licensee has failed to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations. [s. 60. (2)] (523)

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 ensue that if the family Council has advised the licensee of concerns or recommendations, the licensee shall, within 10 days of receiving the advise, respond to the Family Council in writing, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that complied with manufacturer's instructions for the storage of the drugs.

Observation of the central medication cart was done with RPN #133 present. There were two bottles of Alugel liquid with an expiry date of December 2017 and one bottle of Senokot tablets with an expiry date of November 2017 in the central medication cart.

MDS RAI Coordinator# 105 shared that there was an audit schedule form and all of the audits were to be completed by the first weekend of every month.

Review of the audit called "Medication Cart Audit" dated January 9, 2018, stated that it was the responsibility of the evening nurse to complete the audit to ensure that an adequate and non-expired supply of medication was maintained for each resident and to remove any expired medication and discard it. Further review of the "Medication Cart Audit" showed that there was nothing documented in the box for "discard of any expired or discontinued meds."

RN #124 was shown the audit. The RN stated that if nothing was documented in the box it would mean that there were no expired drugs in the cart. RPN #133 acknowledged that it was the responsibility of the night shift to ensure the discontinued drugs were removed but at the same time all of the registered staff were responsible and supposed to check the expiry dates before administering the drugs to ensure that they removed any expired medication and discard it.

The licensee failed to ensure that drugs were stored in an area or a medication cart that complied with manufacturer's instructions for the storage of the drugs. [s. 129. (1) (a)] (532)

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 drugs are stored in an area or a medication cart that complies with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee had failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The Ministry of Health and Long-Term Care received a complaint, where complainant said that resident #059 did not receive their medications for two days.

In an interview complainant said the staff were late in administering the resident's medications.

A review of Policy 3-6, The Medication Pass dated February, 2017, showed that "all medications administered are listed on the resident's MAR. Each resident receives the correct medication in the correct prescribed dosage, at the correct time and by the correct route." A review of the Medication Administration & Medication Errors education provided to staff showed that "medications should not be administered 60 minutes earlier or later that the scheduled time of administration."

In an interview RN #115 said that the expectation was to administer medication within one hour of the administration ordered time, plus or minus. RN #115 said that they were having challenges completing this task especially in the mornings due to work load.

In an interview RPN # 107 said that the expectation was to ensure that medications were administered within the one hour of the assigned administration time but this can be impacted by other factors like work load, incident involving other residents and sick residents.

A review of the Physician Orders Audit Report showed that 66 out of 101 (65%) times over a two week period resident #059 did not have their medication administered within one hour of the scheduled administration times.

In an interview RAI-RN #105 said that the expectation was for the staff to administer medications within one hour plus or minus the scheduled time. RN reviewed the Physician Orders Audit Report and acknowledged that the resident did not receive the medications within one hour of the scheduled time on 65 % of the occasions. RAI-RN #105 said that the expectation was for the medications to be administered within one hour of the time ordered by the physician.

In an interview RCC #121 reviewed the Physician Orders Audit Report and acknowledged that the medications for resident #059 were not administered within the one hour margin identified in the policy. RCC #121 said that they were aware that the bulk of the medications for residents were in the morning and they were working to ensure medication were administered within the one hour plus or minus medication

administration time ordered by the physician.

In an interview Administrator #102 said that the home's expectation was to have medications administered within one hour of the scheduled administration time.

The licensee had failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)] (523)

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A medication incident report documented that a student Practical Nurse (PN) administered the wrong dosage of a medication to a resident. DOC #103 acknowledged that the wrong dose of the medication was administered.

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)] (532)

3. The licensee failed to ensure that member of the registered nursing staff permit a staff member who was not otherwise permitted to administer a drug to a resident to administer a topical only if the staff member was trained by a member of the registered nursing staff in the administration of the topical; the member of the registered nursing staff who was permitting the administration was satisfied that the staff member can safely administer the topical; and the staff member who administered the topical does so under the supervision of the member of the registered nursing staff.

During medication administration and staff interview it was shared by Registered Practical Nurse (RPN) #133 that resident #076 and #077 apply their own topical creams and keep the creams by the bedside.

PSW #140 acknowledged that they do apply the cream for the resident if they were asked, they said that there was a topical cream that they had to mix and then apply. PSW #140 also said that they were trained annually on the administration of topical cream.

Policy called Topical Medication Prescription Shampoo Administration, no date, stated topical creams that were not to be applied by the PSW included:
Topical steroids

Initial doses of topical antibiotics
Medication without Doctor's orders PRN
topical medications.
It further stated that PSWs were permitted to apply topical medication and prescription shampoos after completing the self-learning package, successfully writing the quiz and was signed off by a registered staff member.

During an interview with MDS/RAI Coordinator #105 they said that the PSWs could apply zinc and barrier cream but prescription creams would be applied by registered staff as the PSW staff had not been fully trained to administer topicals so the registered staff could not delegate it.

DOC #103 was asked regarding the training for the personal support staff and if they had the self-learning package or the quiz certificate for administration of creams and ointments. DOC #103 stated that they checked in the education binder for the information and were not able to find any training records for the personal support staff. The DOC #103 shared that it was a delegated act from the registered nursing staff, and as per the policy the staff were to have the training and the self-learning package completed successfully before the administration of topical but there were no records of this in the education binder.

The licensee failed to ensure that member of the registered nursing staff permit a staff member who was not otherwise permitted to administer a drug to a resident to administer a topical only if the staff member was trained by a member of the registered nursing staff in the administration of the topical; the member of the registered nursing staff who was permitting the administration was satisfied that the staff member can safely administer the topical; and the staff member who administered the topical does so under the supervision of the member of the registered nursing staff. [s. 131. (4)] (532)

4. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

During medication administration observation, it was shared by Registered Practical Nurse (RPN) #133 that resident #076 and #077 apply their own topical creams and keep the creams by the bedside. Resident #076 showed the topical creams to Inspector #532 that they administered to themselves.

Policy called Self-Administration of Medications, dated February 2107, stated under procedure that:
"Prescriber and health care professional assesses resident for their capacity to self-administer their own medication and complete "self-Administration Assessment Form". File form in chart or file."
"Prescriber writes the medication order including in the direction "may self-administer" prescriber indicates the amount of medication allowed to be securely stored at the bedside, if other than a standard size package."
"Document in resident's care plan that they have been identified as capable of self-administering medications."

The RAI/MDS Coordinator #105 reviewed resident #076 and #077 charts for the "self-Administration Assessment Form" and none were found.

There were no orders or direction from the prescriber for self-administration for resident #076 and #077.

The care plan was reviewed for resident #076 and #077 and it did not identify the residents as capable of self-administering medications.

DON #103 acknowledged that there should be an order for self-administration of drug from the physician and it should be approved by the prescriber in consultation with the resident and this was not done for resident #076 and #077.

The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. [s. 131. (5)] (532)

5. The licensee has failed to ensure that no resident who was permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident.

Resident #076 showed the topical creams to Inspector #532 that they administered to themselves and kept at the bedside.

The topical cream orders were reviewed with RPN # 163 and they acknowledged that the

topical creams were not to be kept in the room except, if there was authorization by a physician and this was not done.

The licensee has failed to ensure that no resident who was permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident. [s. 131. (7)] (532)

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber; a member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if (a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals, (b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical and (c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff; shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident; to ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except, (a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and (b)in accordance with any conditions that are imposed by the physician, the registered nursing in the extended class or other prescriber, to be implemented voluntarily.

WN #14: 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. (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:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that where 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: 2. A description of the individuals involved in the incident including, ii. names of any staff members or other persons who were present at or discovered the incident.

The home submitted Critical Incident Report that resident #045 was found with a bottle of hazardous chemical. The staff member responsible for leaving the chemical in room was made aware of their error. The Critical Incident Report did not include the staff involved in the incident.

The Director of Nursing #103 said that they were not involved with that Critical Incident Report and that Administrator #102 was aware of the incident. During interview with the Administrator #102, Inspector #155 asked who the staff member was that was present at the time of the incident. The Administrator #102 advised Inspector #155 that they did not know who the staff was but later informed Inspector #155 that it was Personal Support Worker #114.

The licensee failed to ensure that where 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: 2. A description of the individuals involved in the incident including, ii. names of any staff members or other persons who were present at or discovered the incident. [s. 107. (4) 2. ii.] (155)

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were obtained for use in the home, except drugs obtained for any emergency drug supply,storage were obtained based on resident usage, and that no more than a three-month supply was kept in the home at any time.

The central medication room was observed and it was noted that there were 24 bottles of Tylenol 325 milligrams (mg). The north medication room was observed and it was noted that there were 25 bottles of Tylenol 325 mg. All of the 49 bottles had an expiry date of January 2018.

MDS-RAI Coordinator #105 confirmed that there was no policy for obtaining drugs for use in the home and stated that the government supply medications were ordered by the DOC.

The number of drugs and the expiry dates were all examined by both RN # 134 and RPN # 133. The RPN and the RN shared that it was more than a three month supply as the residents receive their own adequate supply of Tylenol in the individual strip packages, and the government stock was only used as requested by the resident (PRN) or sometimes when there was a new order in place. They acknowledged that number of bottles in the medication room were more than a three month supply.

The licensee has failed to ensure that drugs were obtained for use in the home, except drugs obtained for any emergency drug supply,storage were obtained based on resident usage, and that no more than a three-month supply was kept in the home at any time. [s. 124.] (532)

Issued on this 2nd day of March, 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) :	SHARON PERRY (155), ALI NASSER (523), JANETM EVANS (659), MARIAN MACDONALD (137), NUZHAT UDDIN (532)
Inspection No. / No de l'inspection :	2018_448155_0001
Log No. / No de registre :	029094-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 23, Mar 1, 2018
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Fergus Nursing Home 450 Queen Street East, FERGUS, ON, N1M-2Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Charlie Warren

To Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 213. (4) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section,
(a) has at least one year of experience working as a registered nurse in the long-term care sector;
(b) has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and
(c) has demonstrated leadership and communication skills. O. Reg. 79/10, s. 213 (4).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 213. (4)(a)(b)(c).

Specifically, the licensee shall ensure that the long-term care home has an individual employee that is working in the home as the Director of Nursing and Personal Care that has the following:
(a) Has at least one year of experience working as a registered nurse in the long-term care sector;
(b) Has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and
(c) Has demonstrated leadership and communication skills.

The licensee must provide the Director written strategies to ensure Director of Nursing and Personal Care coverage until such time an individual is permanently hired in that position, including the name and qualifications of the individual employee that is working in the home as the Director of Nursing and Personal Care at this time. This information must be submitted to Sharon Perry, LTC Homes Inspector, MOHLTC, by email to Central.West.SAO@Ontario.ca by February 27, 2018.

Grounds / Motifs :

1. The licensee failed to ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section,

(a) had at least one year of experience working as a registered nurse in the long-term care sector;
(b) had at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and
(c) had demonstrated leadership and communication skills.

On February 8, 2018 Inspector #155 called the home and spoke with Administrator #102. They shared that the Director of Nursing #103 had not returned to work after January 31, 2018 when the inspectors left the home and that the DON's last day was February 9, 2018. Inspector #155 asked that the home submit a plan by e-mail regarding Director of Nursing coverage in the home. On February 12, 2018, Inspector #155 received an email from Administrator #102 stating that RN #134 will be covering most of the critical duties of the Director of Nursing while being supported by Independent Consultant #152, corporate supports and by the Resident Care Coordinator #121 who was in the home five days per week.

After receiving the email on February 12, 2018, Inspector #155 phoned the home and spoke with Administrator #102 and asked them to explain how their plan met the Long Term Care Homes Act and Regulations. Administrator #102 said that they were unsure and would look into it. On February 13, 2018 Administrator #102 called Inspector #155 and told them that RN #134 was a Registered Nurse but did not have three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting. Inspector #155 again asked Administrator #102 to provide an update by email of how their plan met the Long Term Care Homes Act and Regulations along with RN #134's resume and credentials.

On February 14, 2018, Inspector #155 received an email from Administrator #102 with their explanation of their plan and RN #134's resume and credentials. The email states that they attached the resume and credentials for RN #134. The email also stated that RN #134 did not meet the requirement of having three years managerial experience in a supervisory role within a long term care facility "as recommended" in Long Term Care regulations. They stated that they are actively in the process of recruiting a new Director of Nursing.

RN #134 did not meet the legislative requirements for the Director of Nursing and Personal Care.

The licensee failed to ensure that the long-term care home had a Director of Nursing and Personal Care that had the following:
(a) At least one year of experience working as a registered nurse in the long-term care sector;
(b) At least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and
(c) Had demonstrated leadership and communication skills.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a level 3 as it had the potential to affect all residents in the home. Compliance history was a level 2 as there was one or more unrelated non-compliance in the last 36 months. [s. 213. (4)]

(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 02, 2018

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_508137_0018, CO #004;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s.53. (4).

Specifically the licensee must ensure there is a process developed and implemented for resident #029, resident #080 and all other residents demonstrating responsive behaviours to ensure strategies have been developed and implemented to respond to the residents responsive behaviours.
The process shall include staff roles and responsibilities including which staff are responsible for monitoring the implementation of the strategies.

Grounds / Motifs :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident were identified, where possible;
(b) strategies were developed and implemented to respond to these behaviours, where possible; and
(c) actions were taken to respond to the needs of the resident, including assessments,
reassessments and interventions and that the residents responses to interventions were documented.

Compliance Order # 004 was issued on September 13, 2017 with a compliance date of October 31, 2017, following a Follow up Inspection. The Compliance Order stated that "The licensee shall ensure there is a process developed and implemented for all residents demonstrating responsive behaviours to ensure strategies have been developed and implemented to respond to the residents' responsive behaviours.
The process shall include staff roles and responsibilities including which staff are responsible for monitoring the implementation of the strategies".

(A) A clinical record review over a period of time, showed resident #029 exhibited several responsive behaviours. The resident's plan of care showed there was only one type of responsive behaviour identified and there was no documented evidence of the other types of responsive behaviours on the plan of care.

Resident #029 had not been assessed, interventions were not developed and implemented to manage the behaviours and there were no procedures or interventions developed and implemented to assist residents/staff who were at risk of harm or were harmed as a result of the resident's responsive behaviours. Risk management reports were not completed. Despite exhibiting responsive behaviours for almost a year, a Behavioural Support Ontario (BSO) referral was not made for the resident until inspectors were in the home.

During an interview with the Registered Nurse - Resident Assessment Instrument (RN - RAI) Coordinator #105, Inspector #137 reviewed the responsive behaviours and the plan of care for the resident. RN - RAI Coordinator #105 said resident #029 definitely had significant behaviours that were not identified on the care plan but should be, resident #029 should have been assessed and a BSO referral should have been made long before now.

During an interview with Registered Nurse - Resident Care Coordinator (RN RCC) #121, Inspector #137 reviewed the responsive behaviours and plan of care for resident #029. RN - RCC #121 said resident #029 certainly had responsive behaviours which were not identified on the care plan, there were no Risk Management reports completed and a referral should have been made to BSO a long time ago.

During an interview on January 23, 2018, BSO - Personal Support Worker #123 (PSW) said resident #029 had behaviours that resulted mainly from a specific

trigger however, BSO PSWs had nothing to do with the care plans. BSO PSWs were not allowed to chart in Point Click Care (PCC) so they created a word document and placed it in the BSO binder. The BSO - RPN then entered the notes in PCC, with their signature.

(B) During an interview Inspector #137 asked Behavioural Support Ontario - Registered Practical Nurse (BSO - RPN) #136 if a process had been developed and implemented for all residents demonstrating responsive behaviours to ensure strategies have been developed and implemented to respond to the residents' responsive behaviours, including staff roles and responsibilities, as well as who was responsible for monitoring the implementation of the strategies. BSO - RPN #136 said there was no formal process in place, what was there was disorganized and Director of Nursing (DON) #103 was responsible for overseeing the BSO team but they were not receptive or supportive to ideas and suggestions offered by the BSO team. The Psychogeriatric Resource Consultant (PRC) made two attempts to meet with DON #103 to discuss their concerns but was unsuccessful.

BSO - RPN #136 said a Psychogeriatric Resource Consultant (PRC) visited the home, approximately three to four times a year and as needed, if requested. The PRC provided the assessment tools used by the home which were kept in a BSO binder for the BSO team to access. Referral forms to the BSO team were available at the central nurses' desk for nursing staff to complete but the folder was usually empty. BSO - RPN #136 said they were familiar with what was expected of them but there was currently no formal process in place that outlined the role and responsibilities of the BSO - RPN or BSO - PSWs and no process that identified who was responsible for monitoring the implementation strategies related to responsive behaviours.

During an interview with Regional Manager #143 and External Consultant #152, the External Consultant said that the current responsive behaviour program needed much work. That was the next program that they will be working on starting in February 2018. As the DON was leaving, there was no one from management overseeing the BSO program currently. It was undetermined as to who was going to take that over, whether a new DON or RCC.

The licensee failed to ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident were identified, where possible;

(b) strategies were developed and implemented to respond to these behaviours, where possible; and
(c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were
documented. [s. 53. (4)] (137)

(137)

2. The licensee has failed to ensure that strategies were developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Review of the Critical Incident System (CIS) indicated that resident #080 was observed by a Personal Support Worker (PSW) exhibiting responsive behaviours. As a result of the incident, resident #080 was placed on a specific intervention and the Pharmacist was asked to complete a medication review for the resident. A record review of the specific intervention was done with MDS/RAI Coordinator #105 and it was noted that the specific interventions were documented in bulk at the end of the shift and not at the scheduled times. MDS/RAI Coordinator # 105 was interviewed and they said that it was difficult to determine if the interventions were actually done at the scheduled times as they were documented all at the end of the shift (in bulk) or if the interventions were done at all.

A progress note indicated that the Nurse Practitioner discussed a proposed switch in medication with resident #080's Power of Attorney (POA). Consent from POA to change medication was not obtained and no changes to current medications was made. NP recommended continuing with the specific intervention, continue to provide and implement non pharmacological approaches.

On eight separate occasions, staff observed resident #080 exhibiting a responsive behaviour. Plan of care for resident #080 indicated that resident had responsive behaviours.
Point of Care (POC) documentation was reviewed and it stated to ensure that resident had no responsive behaviours and a specific intervention was to be completed two times a shift.

BSO RPN #136 and BSO PSW #123 were interviewed regarding resident #080 and the responsive behaviours. BSO RPN #136 went through the progress notes and shared that the resident was on the BSO caseload, they had developed a plan of care for the resident to indicate that the resident had behaviours. BSO RPN #136 explained that more could be done to prevent the incidents. The BSO RPN #136 said they had considered a possible strategy for the resident but this was never implemented. They also indicated that staff required more education in this area of behaviours. They indicated that each manager in the home had provided different direction in terms of how to address the responsive behaviours. They indicated that there was confusion on how to address this responsive behaviour but more strategies could be developed to address the responsive behaviour.

The licensee has failed to ensure that strategies were developed and implemented to respond to resident #080's responsive behaviours.

The severity of this issue was determined to be a level 3 as there was actual harm or risk to the residents. The scope of the issue was a level 2 (pattern). Compliance history was a level 5 as there are multiple non-compliances with at least one related order that included:
Written Notification and a Compliance Order on August 4, 2016, under Inspection # 2016_325568_0015, during a Resident Quality Inspection (RQI);
Written Notification and a Compliance Order on February 24, 2017, under Inspection # 2016_262523_0038, during a Follow up Inspection; and
Written Notification and a Compliance Order on September 13, 2017, under Inspection # 2017_508137_0018, during a Follow up Inspection. [s. 53. (4) (b)] (532) (532)

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_508137_0018, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s.55.

Specifically the licensee must ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Grounds / Motifs :

1. The licensee failed to ensure that, (a) procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff were advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours posed a potential risk to the resident or others.

Compliance Order #005 was issued on September 13, 2017 with a compliance date of October 31, 2017, following a Follow up Inspection. The Compliance Order stated that "The licensee shall ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents".

(A) A clinical record review over a period of time, showed resident #029 exhibited responsive behaviours. There was only one type of responsive behaviour identified and there was no documented evidence of the other types of responsive behaviours on the plan of care for resident #029. Resident #029 had not been assessed, interventions were not developed and implemented to manage the behaviours and there were no procedures or interventions developed and implemented to assist residents and staff who were at risk of harm or were harmed as a result of the resident's responsive behaviours. Risk management reports were not completed. Despite exhibiting responsive behaviours for almost a year, a Behavioural Support Ontario (BSO) referral was not made for the resident until inspectors were in the home.

During an interview Behavioural Support Ontario - Registered Practical Nurse (BSO - RPN) #136 said there was no formal process in place and what was there was disorganized. Mandatory huddles were started shortly after the last Ministry of Health (MOH) visit. The huddles took place twice a day, including week-ends, and all departments attend. Behaviours were included in the discussion. BSO - RPN #136 said a new Responsive Behaviour policy and procedure was developed in September 2017 by Registered Nurse - Resident Assessment Instrument Coordinator (RN - RAI) #105 and Director of Nursing (DON) #103, after the last MOH visit. The policy was sent for review to Head Office, then to the Psychogeriatric Resource Consultant (PRC) and now the External Consultant #152 had it. The policy had not yet been implemented. BSO-RPN #136 said that procedures and interventions had not been developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

During an interview with Regional Manager #143 and External Consultant #152,

the External Consultant said that the current responsive behaviour program needed much work. That was the next program that they will be working on starting in February 2018. As the DON was leaving, there was no one from management overseeing the BSO program currently. It was undetermined as to who was going to take that over, whether a new DON or RCC.

The licensee failed to ensure that,
(a) procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's
behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff were advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring
because those behaviours posed a potential risk to the resident or others.

The severity of this issue was determined to be a level 3 as there was actual harm or risk to the residents. The scope of the issue was a level 1 (isolated). Compliance history was a level 5 as there are multiple non-compliances with at least one related order that included:
Written Notification and a Compliance Order on August 4, 2016, under Inspection # 2016_325568_0015, during a Resident Quality Inspection;
Written Notification and a Compliance Order on February 24, 2017, under Inspection # 2016_262523_0038, during a Follow up Inspection; and
Written Notification and a Compliance Order on September 13, 2017, under Inspection # 2017_508137_0018, during a Follow up Inspection. [s. 55.]
(137)

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 6. (1)(c) of the LTCHA.

Specifically the licensee must:
a) Ensure that the written plan of care for resident #009 provides clear direction regarding the following:
-toileting that includes at a minimum how much assistance is needed transfering on/off the toilet, cleaning self, changing pads/products and adjusting clothing;
-dressing;
-personal hygiene that includes at a minimum how much assistance is needed with combing hair, brushing teeth, washing and drying face, hands and perineum;
-the frequency as to how often the resident is to be toileted;
-if refusing care the interventions that are to be utilized to ensure resident receives care;
-any other information pertinent to the care of the resident.

b) Ensure that the written plan of care for resident #058 included the specific type of alarms used for fall prevention and any other information pertinent to the care of the resident.

c) Ensure that the written plan of care for all other residents sets out clear directions to staff and others who provide direct care to the residents.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care had set out clear directions to staff and others who provided direct care to the resident.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to resident #067 sustaining a fall with injury and required transfer to hospital for assessment.

A review of the plan of care showed the resident had certain functions with mobility however, the Minimum Data Set (MDS) Assessment indicated different functions with mobility.
During an interview Director of Nursing (DON) #103 said that there was a discrepancy and the plan of care did not provide clear direction to staff. During an interview, Resident Assessment Instrument (RAI) Coordinator #105 said that the care plan was ambiguous and did not give clear direction to staff, related to mobility.

The licensee has failed to ensure that the plan of care had set out clear directions to staff and others who provided direct care to the resident.
(137)

2. During stage one of the Resident Quality Inspection resident #008 expressed concerns regarding the toileting care for resident #009. Resident #008 shared that at time the resident was just left without care being provided.

On a specific date, resident #008 shared that resident #009 needed encouragement to get up and that staff need to assist resident #009 with care for toileting, hygiene and dressing. They shared that some PSWs come in and they speak to the resident however, they are not able to understand the PSW and they just leave not giving the encouragement or assistance that the resident needs.

On a specific date, during an interview with PSW #106 they shared that resident #009 required encouragement and prompting to go to the bathroom every two hours as they were incontinent, but with prompting remains dry some of the time. Staff needed to check and assist the resident.

During an interview with PSW #154 they shared resident #009 needed to be encouraged to get up in the morning, they need to be taken to the bathroom and staff need to say with them while cares were done. Resident #009 would assist

with their own care but staff needed to stay with them and assist them to ensure that care was done.

Review of resident #009's care plan identified that the resident required extensive assistance with toileting, dressing and personal hygiene. On a specific date PSW #106 viewed resident #009's care plan with Inspector #155. They agreed that there was no clear direction as to when to toilet resident #009 and that they need to be toileted every two hours. PSW #106 said that new staff would only know to toilet the resident if they were told by them, another staff.

On a specific date, Administrator #102 shared with Inspector #155 and #137 that resident #009 had deteriorated in the last few months and some of the PSWs may have taken for granted that the resident can do more than they can. Administrator #102 shared that resident #008 had expressed that resident #009 needed more cueing and had expressed concerns that some of the PSWs did not know the care that the resident needed.

The written plan of care for resident #009 did not provide clear direction to staff and others who provided direct care to the resident. [s. 6. (1) (c)] (155) (155)

3. The Ministry of Health and Long-Term Care received a complaint, where complainant said that resident #059 did not receive a meal. A clinical record review for resident #059 showed that upon admission a progress note showed that the resident required a specific process for their meals. The process would be provided to the resident because of certain circumstances and the resident would continue until a certain time.

In an interview RN #115 said that the resident still required this process. RN said that the intervention would have to be in the plan of care. RN #115 reviewed the plan of care and found no information regarding this. RN #115 acknowledged that the plan of care for the resident did not provide clear direction to staff or others providing direct care to the resident regarding this specific process. [s. 6. (1) (c)] (523) (523)

4. The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC), which identified that resident #058 had a fall that resulted in injury. On a specific date, PSW #125 and PSW #110 told inspector #523 that the resident was at risk for falls. They said that the resident had a specific safety intervention in place.

Resident observations showed resident #058 with a different intervention in place. On a specific date, RN #115 told inspector that the resident had a specific safety intervention in place and this would be reflected in the plan of care. RN #115 completed an observation with inspector and acknowledged that the resident had a different intervention in place. RN #115 reviewed the care plan and the Kardex in Point of Care and said that the intervention and direction given to the staff was not clear on what intervention to use. RN #115 said that intervention should provide clear direction for the staff on what type of intervention to use. RN #115 said that this does not provide clear direction to the staff on what type of intervention to be used.

On a specific date, PSW #110 told inspector #523 and RN #115 that the resident had a specific safety intervention that should be in place. PSW, RN and inspector completed observation and acknowledged that the resident had a different intervention in place. PSW #110 said that they were not aware that the resident had this intervention.

On a specific date, RN RAI Coordinator #105 reviewed the plan of care with inspector and acknowledged that there was no clear direction given to staff on what type of intervention to use. RN #105 told inspector that they would assess the resident and ensure the correct intervention was in place and that would be reflected in the plan of care.

The licensee has failed to ensure that the plan of care set out clear direction for staff and others who provide direct care to the resident. [s. 6. (1) (c)] (523)
The severity of this issue was determined to be a level 3 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a level 2 (pattern). The compliance history was a 3 (one or more related non-compliances in the last 36 months). The related non-compliance with this section of the LTCHA that included:
Written notification (WN) and voluntary plan of correction (VPC) issued August 18, 2015 (2015_448155_0020). [s. 6. (1) (c)] (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 06, 2018

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

3. A response shall be made to the person who made the complaint, indicating,

i. what the licensee has done to resolve the complaint, or

ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s.101. (1).

Specifically the licensee must ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

3. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

Grounds / Motifs :

1. A) A Spills Action Centre (SAC) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) and a Critical Incident System (CIS) report was submitted.

On a specific date an incident occurred involving a PSW and a resident not receiving care. RN #115 directed PSWs #126 and #154 to provide the specific care to the resident, which they did. RN #115 reported the incident to Resident Care Coordinator (RCC) # 121. RCC #121 reported the concern on a specific date by email, to the Director of Nursing, Administrator, Regional Manager and external Nursing Consultant. Administrator #102 met with PSW #141 the following morning. PSW #141 denied the allegation. The Administrator felt satisfied with the explanation provided by PSW #141. There was no documented evidence that any interviews or follow-up investigation was completed with RN #115, RCC #121 and PSWs # 126 and # 154.

During interviews RN #115 and RCC #121 said they had not been interviewed

related to the incident.

During an interview Administrator #102 said they could have done a better job of the follow-up investigation with the incident involving resident #029.

During an interview, RN #115 said there were concerns related to the provision of care by some recently hired PSWs. There was an incident on a specific date involving a specific care a PSW was providing a resident. RN #115 intervened and requested the resident be removed from the situation. RN #115 requested for another PSW to assist. Resident #012 was removed from the situation but PSW #141 did not know how to perform a function of the task and had to be shown how to complete the task. RN #115 reported the incident to the RCC #121 who sent an email to Director of Nursing (DON) #103 and Administrator #102 on a specific date informing them of the incident and suggested that PSW #141 may need education related to this task.

During an interview Inspector #137 asked DON #103 if there was an investigation related to the incident. DON #103 said that they only found out about the incident when they received an email from RCC #121 at a later date. Inspector #137 showed DON #103 an email that was sent by RCC #121 on the date of the incident, to the DON and Administrator, informing them of the incident. DON #103 said that they were behind in reading their emails. Inspector # 137 said the incident took place almost three weeks ago and, to date, there was no investigation initiated.

During an interview Inspector #137 told DON #103 and Administrator #102 that some staff had told the Inspectors that they bring written concerns forward to management but they are not dealt with.

A review of employee files showed PSW #141 had not been provided orientation for the task used while providing specific care. During an interview, Administrator #102 said that they noticed PSW #141 had not been provided orientation and would not be assigned to that care task until they were orientated. Administrator #102 said that they now started the investigation into the incident and planned to meet with PSW #141 when the DON was available. On the last day of the inspection, Administrator #102 said the interview with PSW #141 would be delayed as DON #103 was not present at the home.

The licensee failed to ensure that every written or verbal complaint made to the

licensee or a staff member concerning the care of a resident or operation of the home where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. (137)

2. RN #115 shared with Inspector #155 that some of the Personal Support Workers that worked the past weekend had complained to them that some of the newly hired Personal Support Workers were using brown paper towels that were in the washroom to wash the residents. RN #115 said that they wrote these complaints down and handed them into the Resident Care Coordinator #121. RN #115 provided Inspector #155 with copies of what they had handed into the Resident Care Coordinator #121.

Review of the copies provided to Inspector #155 stated that on a specific date, PSW #162 reported that during their shift that the care carts that were used on days still had towels and washcloths on them. One cart was totally stocked, and the other two carts had more than half the number of towels and facecloths on them. PSW #151 reported that some of the new staff were using the brown paper towels that were in the bathrooms to wash the residents.

Review of copies provided to Inspector #155 stated that on another date, PSW #162 and #151 showed RN #115 the care carts. Cart #1 had four towel sets, cart #2 had 12 towel sets and cart #3 had 10 towel sets. Evening PSWs said that there should be less towel sets on cart #2 and #3 as they come up to floor stocked with 12 towel sets. RN #115 shared concerns that residents were not being washed properly.

Resident Care Coordinator #121 told inspector #155 that they gave these complaints to Independent Consultant #152 and Regional Manager #143 to give to the Administrator on a certain date.
PSW #151 shared that no one had followed up with them regarding the care issues they shared with RN #115.

Inspector #155 asked Administrator #102 if they were aware of these written complaints completed by RN #115. Administrator #102 said yes, I found those on my desk, I don't know if those were complaints, I spoke with RN #115 and those were their notes. Administrator #102 stated that they suspected that the DON #103 had dealt with these issues.

Administrator #102 was not able to provide any record of investigation or follow

up done. (155)

3. On a specific date resident #008 shared with Inspector #155 that they felt things were getting worse resident #009 was not getting the help with care that they needed and on a specific date resident #009 did not get the care they needed.

Registered Nurse #115 shared that on the specific day, resident #008 did speak to them and Administrator #102 in the Director of Nursing office. RN #115 shared that on that date, resident #008 was upset because it was late morning and resident #009 was still in bed and had not received care. A PSW was directed to get resident #009 up however, continence care and assistance with hygiene and dressing was not provided despite the resident being incontinent.

Administrator #102 shared with Inspector #137 and #155 that on the specific date, they did meet with resident #008 and RN #115 in the Director of Nursing office. Administrator #102 shared that resident #008 had concerns as they felt resident #009 was not getting the care they needed. Administrator #102 stated that some of the PSWs may have taken for granted that resident #009 could do more for themself than they really could. Administrator #102 shared that resident #008 had concerns that the PSWs did not know the care that was needed.

On a specific date, when Inspector #155 asked the Administrator what investigation was done in regards to resident #008's complaint regarding the care of resident #009 they shared that they spoke to RN #115 to address the PSWs. Inspector #155 asked the Administrator if they had followed up with resident #008 about the complaint and Administrator #102 shared that they had not.

Resident #008 shared that Administrator #102 and no other staff had spoken to them about the complaint about resident #009's care.

The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. [s. 101. (1)] (155)

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

to the residents. The scope of the issue was a level 2 (pattern). The compliance history was a 2 (one or more unrelated non-compliances in the last 36 months). [s. 101. (1)]
(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 06, 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 23rd day of February, 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 : SHARON PERRY

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