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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 16, 2015	2015_327570_0027	O-002642-15	Resident Quality Inspection

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East WHITBY ON L1N 6A3

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

LAKEVIEW MANOR
133 Main Street P.O. Box 514 Beaverton ON L0K 1A0

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

SAMI JAROUR (570), BAIYE OROCK (624), KELLY BURNS (554), MARIA FRANCIS-ALLEN (552)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 28-30, October 01-08, 2015.

Critical Incident Logs #O-002807-15, O-002780-15, O-002661-15, O-002768-15; Follow up Log #O-002505-15 and Complaint Log #O-002422-15 were inspected concurrently during this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Director of Care (DOC), Resident Care Coordinators (RCC), Registered Nurses(RN), Registered Practical Nurses (RPN), Nursing Practice Leader, Personal Support Workers (PSW), RAI Coordinator, Residents, Family members, President of the Residents' Council, President of the Family Council, Environmental Service Manager, Social Worker, Housekeeping Aide, Registered Dietitian, Dietary Aide, and Physiotherapist.

During the course of the inspection, the inspector(s) completed an initial tour of the home, observed dining service, staff to resident interactions, recreation/program activities, meals and, observed residents' environment including individual resident rooms and common areas, observed medication administration and infection control practices; reviewed health care records, reviewed Family and Residents' Council meeting minutes, and reviewed the home's policies relate to: Prevention, Reporting, and Investigation of Abuse and Neglect, Falls Prevention and Management Program, Restraint Minimization, Reporting and Complaints, Medication Administration Program, Nutrition Care and Dietary Services, and Hand Hygiene Program.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2015_360111_0010	570

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 comply with LTCHA, 2007, s. 20 (1), by not ensuring the

home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The home's policy, Prevention, Reporting, and Investigation of Abuse and Neglect (#ADM-01-3-05), defines "sexual abuse" as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or a staff member.

The home's policy, Prevention, Reporting, and Investigation of Abuse and Neglect directs the following:
- All staff must immediately report any alleged, suspected or witnessed incidents of abuse to the appropriate supervisor on duty. If there are reasonable grounds to suspect that abuse has occurred or may occur, the home must immediately report to the MOHLTC;
- Mandatory reporting to MOHLTC is required for abuse, including sexual abuse;
- Ensure that the family (substitute decision maker / power of attorney for personal care) has been notified of the incident, if the resident is not capable; immediate notification if the incident involved physical pain or injury or caused distress to the resident;
- Investigation process will commence immediately to determine if there are reasonable grounds to suspect the alleged, suspected or witnessed abuse has occurred; supervisor, manager or delegate is responsible for initiating the investigation commencing with documentation of details, using the Resident Abuse Allegation Report;
- Supervisor, manager or delegate will notify the Director of Care or on call manager of the allegation and investigation;
- If there are reasonable grounds to suspect that the alleged abuse is criminal in nature the incident must be reported to the Durham Regional Police; policy makes reference to the criminal code. (554)

Related to Log #O-002661-15

A review of progress note of Resident #041 indicated an entry on identified date: "Resident had 5 incidents of inappropriate touching of females. 2 staff and 1 resident (#050). Resident #041 put hand on resident #050's legs. Required to be redirected immediately".

Interview with RPN #112, who documented the progress note entry, indicated that she did not report the incident to the supervisor on duty but was aware that the expectation is to report to the RN and the RN will make the decision to report to either the Ministry of

Health and Long-Term Care (MOHLTC) or the Resident Care Coordinator.

Interview with RN #105, who was assigned charge nurse when the incident was documented by RPN #112, indicated to Inspector #624 that this incident would be considered an abuse. RN #105 further indicated that she was not sure if the incident was reported to her. The RN indicated if the incident was reported to her, she would have reported it to her supervisor.

Interview with RCC #127 indicated to Inspector #624 that she was not aware of the incident involving Residents #041 and #050. [s. 20. (1)]

2. Related to Log #O-002780-15:

According to the progress notes, for Resident #024 and Resident #047, a witnessed incident of resident to resident sexual abuse occurred during the supper time meal on an identified date. Resident #024 was seen touching, stroking co-resident's arm and rubbing their body against Resident #047; the interaction was non-consensual and upsetting to Resident #047.

The home's policy, Prevention, Reporting, and Investigation of Abuse and Neglect was not complied with as evidenced by the following:
- During an interview, RPN #121 indicated to Inspector #554 that despite redirection from staff Resident #024 continued to touch Resident #047, which prompted Resident #047 to leave the dining room. RPN #121 indicated she did not report the witnessed sexual abuse to RN #130 during her shift. RN #130 indicated the incident was not reported to her until approximately 2130 hours.
-RPN #121 and RN #130 both indicated Resident #047 was upset by the interactions with Resident #024. Both registered nursing staff indicated that the witnessed incident of sexual abuse was not reported to Resident #047's SDM until next day.
- RN #130, who was assigned the charge nurse role, on day of incident, indicated she did not investigate the sexual abuse incident and did not speak with either Resident #024 or Resident #047.
- Resident Care Coordinators and Director of Care all indicated not being told of the witnessed incident of resident to resident sexual abuse until evening of next day.
-Witnessed incident of sexual abuse (resident to resident) was not immediately reported to the Director or to the police, as RN #130 did not deem the incident to be sexual abuse as both Resident #024 and Resident #047 had a history which included cognition impairment. RN #130 and RPN #121 indicated being familiar with the home's policy

Prevention, Reporting, and Investigation of Abuse and Neglect; both registered nursing staff indicated being aware that Resident #047 was bothered by the incident, voicing displeasure and being uncomfortable by the advances of Resident #024; both indicated the interaction was not consented to by Resident #047, hence prompting resident to leave the dining room to avoid any further interactions.

Resident Care Coordinators and Director of Care indicated it is an expectation that all staff follow the home's policies, and indicated RPN #121 and RN #130 did not follow the home's Prevention, Reporting, and Investigation of Abuse and Neglect. [s. 20. (1)]

Additional Required Actions:

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

WN #2: 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. Related to Log #O-002780-15:

The licensee has failed to comply with LTCHA, 2007, s. 24 (1), by not ensuring the person who had reasonable grounds to suspect that any of the following has occurred or may occur immediately report the suspicion and the information upon which it was based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" is defined as (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

The Resident Care Coordinator submitted a Critical Incident Report (CIR) to the Director with regards to a witnessed incident of resident to resident sexual abuse, which was said to have occurred on identified date; the incident was reported to the MOHLTC via the after-hours phone number approximately 24 hours following the incident.

As per the CIR and a review of the progress notes, specific to Resident #024 and Resident #047, the following incident was witnessed by RPN #121:
- Resident #024 was witnessed hovering, stroking co-resident's arm and rubbing their body against Resident #047; the incident was said to have occurred in the dining room, during the suppertime meal. According to the progress notes, Resident #047 was bothered by the interaction and indicated to staff in the dining room that he/she can't make Resident #024 stop; Resident #047 told staff that he/she was going to stop coming to meals if Resident #024 continued with this behaviour.

RPN #121, who is the supervisor of the resident home area, reported the witnessed incident of resident to resident sexual abuse to RN #130, who was the assigned charge nurse on the day of the incident.

RN #130 was interviewed and confirmed to the inspector that RPN #121 did report the resident to resident sexual abuse incident to her at a later hour at night on the the same day of the incident. RN #130 indicated that the incident was not reported to Ministry of Health and Long-Term Care (MOHLTC).

Resident Care Coordinators indicated they became aware of the sexual abuse incident while reviewing the progress notes on the next day of the above incident, and contacted the after-hours MOHLTC number to report the resident to resident sexual abuse.

Director of Care indicated that the expectation would be that the RN would contact the Resident Care Coordinator of abuse incidents, and in turn the Resident Care Coordinator would immediately contact the Director to report the alleged, suspected or witnessed abuse.

Resident Care Coordinators and the Director of Care, all, indicated that the incident on an identified date was deemed sexual abuse (resident to resident) and should have been immediately reported to the Director. [s. 24. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Regarding Resident #004 related to falls:

Resident #004 was admitted to the home with a number of medical diagnosis. The resident ambulates on the unit with a walker.

Review of the clinical health records indicated resident #004 is at risk for falls due to unsteady gait. Interview with RPN #132 who explained the resident is at risk for falls and these often occur during the times the resident attempts to independently use the toilet.

On two different dates, Inspector #552 observed Resident #040 ambulating on the unit from bedroom to lounge area using a walker, has an unsteady gait and was being supervised by staff.

For an identified period of four months, the resident has had seven falls; the resident fell three times in one identified month.

During an interview, RN #105 explained to Inspector #552 that a comprehensive post fall assessment is completed if the resident has had three falls in a month or if following a fall the resident sustained significant injury. This information was confirmed by RCC #127 and the Director of Care (DOC).

There is no documented evidence found to support the resident was assessed using the post fall assessment following the three falls that occurred in an identified month. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident has fallen, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. Related to Log #O-002780-15:

The licensee has failed to comply with O. Reg. 79/10, s. 98, by not ensuring that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The Resident Care Coordinator submitted a Critical Incident Report on an identified date for a witnessed incident of resident to resident sexual abuse which occurred on an earlier date.

RPN #121 indicated that Resident #024 was touching, stroking co-resident's arm and rubbing their body against Resident #047. RPN #121 indicated Resident #047 was upset by the interaction and indicated not being able to make Resident #024 stop; as per RPN #121 Resident #047 voiced being uncomfortable with Resident #024's advances.

RPN #121 indicated the witnessed resident to resident sexual abuse was reported to RN #130, who was the assigned charge nurse on duty on the same date of the incident.

RN #130 indicated they did not notify the police department of the incident of sexual abuse, as both residents were cognitively impaired.

The incident of witnessed resident to resident sexual abuse was reported to the police in the evening of next day; the police did investigate the incident.

Resident Care Coordinator and the Director of Care indicated that the incident should have been reported to the police on the same day of the incident, as the incident was upsetting and considered non-consensual by Resident #047. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #5: 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 written plan of care for each resident set out, (a) the planned care for the resident.

Regarding Resident #037 related to responsive behaviours:

Resident #037 was admitted to the home with several medical diagnosis including dementia.

Review of the clinical health records indicated the resident #037 is exit seeking and this behaviour is exhibited mostly in specific time of day.

Interview with RPN #113 indicated to Inspector #552 that the behaviours the resident exhibits are exit seeking and increased anxiety. These behaviours are mostly exhibited in specific time of day. Interventions include taking the resident to their room to de-escalate behaviours and to remove from crowded noisy environment. Also sitting and speaking with the resident about family is another strategy used. The resident is given medication if behaviours are not easily altered. At times, the resident will also experience shortness of breath and medication have to be administered. The resident enjoys one to one contact and this is another strategy used to de-escalate behaviours.

During an interview with PSWs #115 and #116 who explained to Inspector #552 that the resident exhibits exit seeking behaviours and will try to go through the large window at the end of the hall with walker. When the resident decides on wanting to leave, the resident just wants to go. The resident exhibits these behaviours towards the end of the day shift - is sun downing. Staff try to distract the resident - when behaviours escalate. PSW #116 indicated strategies used by the staff in attempt to de-escalate the resident's behaviours include distraction, allowing the resident to go out to the enclosed area outside. These strategies are short term only.

The resident was observed walking in the hallway and indicated to Inspector #552 being ready to leave. PSW #115 opened the patio door so the resident was able to go outside for a few minutes.

Review of the care plan indicated the exit seeking behaviour is identified but there is no written interventions in the plan of care to address or de-escalate this behaviour. [s. 6. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 8 (1)(b), by not ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to monthly weights, re-weighs and dietary referrals.

Under LTCHA, 2007, s. 11 (1), every licensee of a long-term care home shall ensure there is an organized program of nutrition care and dietary services to meet the daily nutritional needs of the residents; and an organized program of hydration for the home to meet the hydration needs of the residents.

Under O. Reg. 79/10, s. 68 (1), organized program of nutrition care, dietary services and hydration required under clause 11 (1) (a) of the Act.

Under O. Reg. 79/10, s. 68 (2) (e), every licensee of a long-term care home shall ensure that the programs include, a weight monitoring system to measure and record with respect to each resident , weight on admission and monthly thereafter.

The home's policy, Significant Unplanned Weight Change (#INTERD-03-01-19), last revised October 2011, directs that the Personal Support Workers will weigh residents monthly and document the weight on the worksheet in the weight book; registered nursing staff will record the weights from the weight book on Goldcare (electronic health record) vital signs sheet by the tenth day of each month; re-weights to be completed and documented by the fifteenth of each month. Registered Nursing Staff will request re-

weighs to be taken of any resident where there is a gain or loss of two decimal two (2.2) kilograms from the previous weight; registered nursing staff will document in the progress notes significant information that may attributed to the resident's weight change (e.g. eating patterns, infection, change in medical condition). If a weight was not taken because resident refuses (or was hospitalized), this must be entered onto the vital signs record.

The home's policy, Dietitian Referral (#FOOD-04-06-04), last revision April 2013, directs that the Registered Dietitian will be notified, in a timely fashion, when a resident's condition changes in a way that impacts their nutritional health and well-being, to ensure appropriate nutrition intervention can be initiated and monitored. The following are considered appropriate reasons for initiating a Registered Dietitian referral, significant weight change.

Resident #038 was identified by the inspector, during the Resident Quality Inspection, to have had weight loss.

A review of Resident #038's health record (vital signs and weights in Goldcare) indicated the following:
- identified month and weight indicated loss of 7.7 kg since two months prior)
- identified month and weight indicated loss of 7.1 kg since previous month, or 14.8 kg since three months prior.

RPN #113, who is the full-time day nurse on the resident home area, indicated to Inspector #554 not being aware of Resident #038 having lost any weight and that no dietary referrals had been sent to the Registered Dietitian specific to Resident #038's weight loss. RPN #113 indicated Resident #038's recorded weight loss during two consecutive months seemed significant and indicated no re-weigh of resident had been completed; RPN #113 indicated not knowing of the home's policy regarding re-weigh of residents and further indicated the Registered Dietitian would contact nursing staff if a resident requires a re-weigh.

Registered Dietitian (RD) #205 indicated being aware that Resident #038 was having dental problems and commented that resident's diet texture was altered as a result; resident was seen by denturist. RD #205 indicated that Resident #038's weight identified in two consecutive months were most likely an error; RD #205 further indicated that registered nursing staff should have initiated a re-weigh of Resident #038 and a dietary referral should have been initiated.

2. A random clinical health record indicated monthly resident weights were not being consistently taken as per the home's policy; the following resident's weights were not taken during the following time periods:

- Resident #007 – no recorded weights for identified two consecutive months.
- Resident #022 – no recorded weights for identified two months.
- Resident #024 – no recorded weight for identified one month.
- Resident #039 – no recorded weights for identified two consecutive months.
- Resident #070 – no recorded weights for identified two consecutive months.
- Resident #071 – no recorded weight for identified one month.

RN #105, who is a charge nurse, RPN #109 and #113, as well as the Registered Dietitian indicated not being aware of any reason why the identified resident's weights had not been taken.

RD #205 indicated that there are times when monthly (or months) when all resident's weights are not completed, despite reminders to nursing staff to complete weights by the tenth day of each month; RD #205 further indicated rarely are re-weighs of resident's completed without her prompting staff and even then re-weights still may not be completed, which affects her ability to calculate loss or gains in resident weighs and or initiate nutritional interventions in a timely fashion. [s. 8. (1) (a),s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made during the initial tour of the home during the inspection:
- ARJO tub, located on identified resident home area, was observed to have a hole (approximately twelve centimetres in length by six centimetres in width) in the outer aspect of the acrylic tub surround; the exposed surface is porous in nature. PSWs interviewed indicated that this tub is in use for resident bathing. Porous surfaces present cleaning challenges for staff as debris and moisture may collect and such poses an Infection Control risk.
- Flooring: the laminate flooring threshold (expansion joint) between the fire doors (by dining room and resident room hallway); located on an identified residents' home area, was noted cracked and torn in areas (area measures approximately sixty centimetres in length by six centimetres in width); the sub-flooring is exposed with build-up of dust and debris. Flooring issues of a similar nature were noted on two identified residents' home areas) – expansion joint (flooring threshold) between fire doors were cracked. Uneven floor surfaces present mobility challenges to residents and may increase the risk for falls.

- Flooring: 'stone guard' flooring in tub and shower rooms, was noted to be cracked along the flooring (wall to wall); in all rooms identified, the flooring was wet in these rooms and water was observed seeping into the cracks of the flooring; as per Personal Support Workers interviewed, the tub and shower rooms identified are in use for resident care (e.g. bathing).

Personal Support Workers and Housekeeping Staff interviewed, indicated that any repairs and or maintenance concerns are communicated using the work hub, which is the home's electronic maintenance work request system; all requests go directly to the Environmental Services Manager and or Maintenance Staff for follow up.

The Environmental Services Manager indicated the following:
- the flooring issues identified in the tub/shower rooms were identified approximately two years ago and were brought to the Licensee's attention; as of this time no plans are in place for the repair and or replacement of the flooring in the tub/shower rooms;
- the flooring threshold being cracked has been identified, but ESM indicated not being

aware of the extent of the flooring being cracked; as of this time, no plans are in place for the repair and or replacement of the identified threshold flooring;
- no awareness of the ARJO tub surround being damaged (hole in tub surround); indicated staff had not brought this to his attention, via the home's electronic maintenance work hub.

Environmental Services Manager indicated the expectation is that the home, furnishings and equipment are kept in a safe condition and in a good state of repair. [s. 15. (2) (c)]

WN #8: 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 ensure that he licensee respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

Review of the Family Council minutes of identified month indicated that during the meeting the following concerns/recommendations were mentioned:
- the recommendations were made by the Council that better signage was needed in the washrooms, chapel and reception area. The concern was that the writing on the current signage was too small and needed to be larger.
During an interview, the Family Council president indicated to Inspector #552 that the council did not receive a written response to the concern raised regarding the signage.

During an interview with the Acting Administrator, she indicated that she had not responded to the Family Council in writing within 10 days as she felt that a written response was only required when the concern and/or recommendation is formally documented. She acknowledged that a written response was not sent within 10 days to the Family Council. [s. 60. (2)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Related to Log #O-002780-15:

The licensee has failed to comply with O. Reg. 79/10, s. 97 (1) (a), by not ensuring the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that, results in a physical injury or pain to the resident, or causes distress to the resident that could potentially be detrimental to the resident' s health or well-being.

A Critical Incident Report (CIR) to the Director with regards to an witnessed incident of resident to resident sexual abuse, which was said to have occurred on identified date.

As per the CIR and a review of the progress notes, specific to Resident #024 and Resident #047, the following incident was witnessed by RPN #121:
- Resident #024 was witnessed hovering, stroking co-resident’s arm and rubbing their body against Resident #047; the incident was said to have occurred in the dining room.

A Progress note indicated Resident #047 was bothered by the interaction and indicated to staff in the dining room that they couldn’t make Resident #024 stop; Resident #047 indicated to staff not coming to meals if Resident #024 continued with this behaviour.

As per progress notes, Resident #047 remained upset by the interaction and continued to voice displeasure to staff and family for days following the incident.

Interviews with RPN #121, RN #130, Resident Care Coordinators (RCC), and the Director of Care, all indicated Resident #047 was upset as to the interaction and felt uncomfortable being touched by Resident #024.

RN #130 and and RPN #121 indicated that the substitute decision maker (SDM) was not notified of the incident; both indicated they did not think to contact the SDM at the time of the incident.

Resident Care Coordinator indicated Resident #047’s SDM was notified of the witnessed sexual abuse incident on next day, almost 24 hours post incident.

Resident Care Coordinator and the Director of Care indicated that Resident #047's substitute decision maker should have been notified on same day of the incident, especially noting that resident was upset. [s. 97. (1) (a)]

WN #10: 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 failed to comply with O. Reg. 79/10, s. 129 (1) (a), by not ensuring that drugs are stored in an area or a medication cart, that is secure and locked.

The home's policy, Medication Administration Program (#INTERD-03-03-19) directs that all drugs, when not in use, are to be stored in an area or medication cart that is secured and locked.

On identified date, Medication Administration was observed on an identified resident's home area, the following observations were made:

- Several medications were observed sitting on the top of the medication cart while RPN #113 left medication cart to administer medications to residents; the RPN #113 had her back to the cart and was approximately fifty feet from the cart; residents were observed walking past the medication cart during this observation.

- A bowl of porridge was observed on the medication cart, there was a blackish-brown substance on top of the porridge. The bowl of porridge was left sitting on top of the cart; there were several times during this observation that the medication cart was left unattended by RPN #113. At one point, RPN #113 took the bowl of porridge and gave it to a resident who was seated in the dining room. Inspector inquired as to what the blackish-brown substance on top of the porridge was, RPN #113 indicated the bowl of porridge contained the resident's medications; residents were observed wandering past the medication cart when the bowl of porridge was observed to be unattended.

RPN #113 indicated knowing that medications were not to be left unattended on medication carts.

Resident Care Coordinator indicated that medications are at no time to be left unattended on the medication carts and that all medications when not in use are to be locked inside the medication cart. RCC indicated there is a risk that a resident from a specified home area would ingest medications unknowingly; RCC indicated that the actions of RPN #113 poses a potential safety risk to residents. [s. 129. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 229 (4), by not ensuring staff participate in the implementation of the infection prevention and control program.

The home's policy, Hand Hygiene Program (#IC-05-02-04), directs that all staff will follow "The Four Moments of Hand Hygiene", which indicates that hand hygiene will be performed before initial contact with resident or resident environment; before aseptic procedures (e.g. before administering medications); after body fluid exposure risk; and after resident/resident environment contact.

During a breakfast medication administration pass, RPN #113 was observed administering medications to five residents without performing hand hygiene either before or after contact with residents.

RPN #113 indicated being aware of "The Four Moments of Hand Hygiene" and having had annual training (or re-training) specific to the importance of hand hygiene; RPN #113 indicated that she normally cleanses hands when going from resident room to resident room, but at times forgets to cleanse hands using alcohol based hand rub (ABHR) when administering medications in the dining room. RPN #113 indicated that the expectation would be to use ABHR between residents before and after administering medications.

Resident Care Coordinator indicated all staff are to follow The Four Moments of Hand Hygiene, which would include cleansing hands using ABHR before and after medication administration. [s. 229. (4)]

Issued on this 11th day of December, 2015

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

Original report signed by the inspector.