Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Aug 30, 2016;	2016_391603_0007 (A1)	008916-16	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE YORK
333 YORK STREET SUDBURY ON P3E 5J3

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

SYLVIE LAVICTOIRE (603) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee requested a compliance date extension from September 14, 2016, to September 30, 2016, for CO #002 and a compliance date extension from August 31, 2016, to September 30, 2016, for CO #003. These compliance date extensions were approved by SSAO Manager.

Issued on this 30 day of August 2016 (A1)

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

Original report signed by the inspector.

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

SYLVIE LAVICTOIRE (603) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): April 18-22, 25-28, 2016

During the course of the inspection, the inspector(s) directly observed the delivery of care and services to residents, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, reviewed various home policies, procedures, and programs, reviewed staff education attendance records, reviewed one Follow Up Order, thirteen Critical

Incident Reports, and four Complaints sent to the Ministry of Health and Long-Term Care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOCs), Support Service Manager, Dietary Manager, Food Services Supervisor, Registered Dietitian, Social Worker, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Maintenance Staff, Dietary Aids, Director of Care Clerk, residents, family members, and volunteers.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

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

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.

- **17 WN(s)**
- **9 VPC(s)**
- **5 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

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

Inspector #627 reviewed a Critical Incident Report (CI) submitted to the Director. The CI alleged staff to resident abuse; whereby, PSW #122 and RPN #123 inappropriately transferred resident #033. Resident #033 had reported the incident to their family member, who reported the information to ADOC #125.

Inspector #627 reviewed the home's investigation notes, which revealed a written interview with PSW #122 who stated that they had transferred resident #033 with a two staff assist (one staff member on each side of the resident) with RPN #123, stood resident #033 up and pivoted them. The same technique was utilized when they returned the resident to bed.

Inspector #627 reviewed the home's progress notes, which revealed that as per the request of the DOC, a resident head to toe assessment was completed with no injury identified.

Inspector #627 reviewed resident #033's care plan at the time of the incident,

which revealed a focus for "Transfer r/t physical limitation" and the interventions included a specific mechanical lift with two staff.

Inspector #627 interviewed PSW #122 who explained that it was the home's expectation that a two person transfer should be done with a specific mechanical lift. PSW #122 also explained that this type of transfer was to ensure resident and staff safety. PSW #122 further explained that RPN #123 had assisted them to transfer resident #033 by standing and pivoting the resident. PSW #122 confirmed that they had not used a specific mechanical lift due to a time constraint. PSW #122 confirmed that a specific mechanical lift should have been used.

An interview with the ADOC #125 confirmed that the care set out in the plan of care was not provided to the resident, as specified in the plan of care and should have been. [s. 6. (7)]

2. The licensee has failed to ensure that staff and others who provided direct care to the resident were kept aware of the contents of the plan of care and had convenient and immediate access to it.

Inspector #603 reviewed resident #035's progress notes which revealed a history of specific responsive behaviours. The most recent specific responsive behaviour happened when resident #035 was in a certain area of the home and a PSW witnessed resident #035 grab resident #025. Resident #035 was removed from the situation and told that their behaviour was inappropriate.

A review of resident #035's care plan identified a focus for specific responsive behaviours.

An interview with the attending RN #101 explained that resident #035 was known to have specific responsive behaviours and this had been identified in the resident's care plan.

An interview with the attending RPN #126 revealed that they were not aware of resident #035's specific responsive behaviours. They explained that they had not listened to the morning report, nor had they looked at any of their assigned resident's care plan before the start of their shift because they had no time.

An interview with the DOC revealed that the home's expectation was that all attending staff were to review their assigned residents' care plans and the shift

report before the start of their shift. In this case, attending RPN #126 was not aware of resident #035's specific responsive behaviours that had been identified in the resident's care plan. [s. 6. (8)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan was not effective.

Inspector #603 reviewed a Critical Incident Report (CI) reported to the Director. The CI alleged resident to resident abuse.

A review of resident #035's progress notes revealed that they had a history of specific responsive behaviours on six different dates.

A review of the resident's care plan identified a focus for specific responsive behaviours; however, there were no interventions such as further assessments, care planning interventions, restricted areas, or increased monitoring to minimize the risk of altercations and future harmful interactions between residents. The care plan offered only immediate guidance and reactive actions for when the resident displayed specific responsive behaviours.

An interview with RN #101 confirmed that other then redirecting resident #035 and telling them that their behaviour was inappropriate, there were no other interventions in the care plan.

A review of the home's policy titled "Responsive Behaviours" revealed guidelines and suggestions for when further assessment and care planning interventions were needed. These included when the resident is not responding to pharmacological interventions, the resident is escalating despite interventions implemented, or when the resident whose behaviours place the resident or others at risk of harm.

In this case, the resident continued to display specific responsive behaviours despite pharmacology intervention and Behavioural Support Ontario (BSO) involvement. The care plan offered no new guidance for further assessments, care planning interventions, restricted areas, or increased monitoring. [s. 6. (10) (c)]

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.

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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan is not effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #603 reviewed a Critical Incident Report (CI) submitted to the Director. The CI indicated that resident #034 reported to registered staff that resident #035 woke them up and displayed specific responsive behaviours.

A review of resident #035's care plan revealed that they displayed specific

responsive behaviours. The care plan offered no interventions such as increased monitoring or restricted areas, to minimize the risk of altercations and potential harmful interactions between residents.

A review of resident #035's progress notes revealed a history of specific responsive behaviours toward other residents and staff members. During a one year span, the resident displayed fourteen specific responsive behaviours. The progress notes also indicated that a third party had been involved with resident #035 for some time and because of specific responsive behaviours.

During a review of resident #035's health care record, the Inspector noted additional specific responsive behaviours that occurred towards two other residents (#036 and #025) by resident #035.

1) A review of resident #036's progress notes revealed that on a certain date, resident #035 was seen touching resident #036, which made them upset and caused them to cry. RPN #111 addressed resident #035 about their inappropriate behaviour and redirected them away from the scene. Another progress note revealed a second incident where resident #035 approached resident #036 and proceeded to touch them inappropriately. According to the progress note, the PSW who witnessed this act, proceeded to remove resident #035 and brought them to a different area.

O. Reg. 79/10, s. 2 (1) defines emotional abuse between residents as any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, action, behaviour or remarks understands and appreciates their consequences.

A review of resident #036's care plan revealed that there were no interventions to keep resident #036 safe from resident #035 as they had been a victim previously.

An interview with the DOC confirmed that resident #035 had a history of exhibiting abusive behaviours. The DOC explained that in most of these incidents of inappropriate behaviours involving resident #035, the staff focused on their responsive behaviours and not on abuse. The DOC confirmed that the incident of abuse that occurred on a certain date, where resident #035 touched resident #036 was not investigated, reported to the Director, nor was it reported to resident #036's Substitute Decision Maker (SDM), because the home did not consider this

abuse. The DOC also explained that the home had not reported the second incident of abuse by resident #035 to resident #036, to the Director or to the police, and had not done an investigation. The DOC could not explain why the second incident of abuse was not investigated or reported.

A review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" revealed that any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse is required to contact the MOHLTC (Director), disclosure to the resident's SDM, notify the Police, and immediately initiate a dignified and respectful investigation of the alleged, suspected or witnessed abuse.

An interview with the Administrator revealed that the home recognized that they had addressed the second incident incorrectly and failed to view this as abuse.

2) A review of resident #035's progress notes revealed a history of specific responsive behaviours towards staff and residents. On a certain date, resident #035 was found inappropriately touching resident #025. Resident #035 was told to keep their hands to themself and was redirected out of the area. On another date, a second incident occurred where PSW witnessed resident #035 inappropriately touching #025. Resident #035 was removed from the situation and told that their behaviour was inappropriate and that if they did this again, the police would be called.

O. Reg 79/10, s. 2 (1) defines sexual abuse as any non-consensual touching, behaviour or remarks or a sexual nature or sexual exploitation by anyone.

An interview with PSW #135 who was present at the second incident, revealed that after this incident resident #025 told them that they did not want this behaviour and stated: "I don't want them around here anymore". PSW #135 told resident #025 that this type of behaviour was unacceptable and that they had informed resident #035 that it was not appropriate. According to PSW #135, this conversation seemed to satisfy resident #025. PSW #135 also explained that for some unknown reason, resident #035 seemed to target resident #025 with specific responsive behaviours. Inspector asked what had been done to prevent such interactions between resident #035 and #025, and PSW #135 explained that there was no heightened monitoring for resident #035's specific responsive behaviours; however, the staff were aware that as soon as resident #035 finished their meals, the staff facilitated the resident's exit out of the specific area.

Inspector #620 interviewed resident #025 regarding the incident of alleged abuse. The Inspector asked the resident whether they recalled an incident involving a certain resident. Resident #025 confirmed that another resident inappropriately touched them and that it was witnessed by a staff member. The resident was unable to remember what the resident's name or the name of the staff member who witnessed the event. The resident stated that the staff member said that they (the staff member) needed to stop what had occurred. The resident recalled being offended by the other resident's actions and they were unsure why the resident did it. Resident #025 stated that they saw the offending resident all the time and that they had inappropriately touched them on many occasions. The resident stated that they tried to get away but that sometimes the resident approached them from behind. Resident #025 stated that they got mad and told the resident to, "stop it" and to, "get away." The resident also stated that the offending resident often tried to put their hands on resident #025's shoulder and that they pushed them away. The resident stated that they did not like the offending resident and did not like being touched by them.

Inspector #603 interviewed the DOC who was surprised that resident #025 would have brought forward concerns about specific responsive behaviours towards them, by resident #035. The DOC explained that they were under the impression that resident #025 consented to the specific responsive behaviours as they were capable of making their own decisions. The DOC confirmed that there had been no formal assessment completed to determine if resident #025 had consented to the specific responsive behaviours by resident #035.

Inspector reviewed resident #025's care plan which revealed that the resident was unable to make decisions for themself. A review of the resident's most recent MDS assessment revealed that they were not independent for daily decision making.

A final interview with the DOC revealed that the home had incorrectly assumed that resident #025 had consented to resident #035's specific responsive behaviours and explained that the incidents on two certain dates, were not investigated, not reported to the Director, Police, or to resident #025's SDM, because the home did not consider these incidents as being abusive.

A review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" revealed that any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse is

required to contact the MOHLTC (Director), disclosure to the resident's SDM, notify the Police, and immediately initiate a dignified and respectful investigation of the alleged, suspected or witnessed abuse.

According to the LTCHA 2007, s. 23, every licensee of a long-term care home shall ensure that, every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated. Two incidents of alleged abuse involving resident #035 toward resident #036 on two certain dates, were not investigated. In addition, two incidents of alleged abuse involving resident #035 toward resident #025 on two other dates, were not investigated.

According to the LTCHA, 2007, s.24 (1) 2, 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, immediately report the suspicion and the information upon with it is based to the Director. Two incidents of alleged abuse involving resident #035 toward resident #036 on two certain dates, were not reported to the Director. In addition, two incidents of alleged abuse involving resident #035 toward resident #025 on two other dates, were not reported to the Director.

According to the LTCHA, 2007, r.97 (1) (a), the resident's SDM and any other person specified by the resident are to be immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being. Resident #036's SDM was not notified of an alleged incident of abuse involving resident #035 on a certain date. In addition, resident #025's SDM was not notified of two alleged incidents of abuse involving resident #035, on two other certain dates.

According to the LTCHA, 2007, s. 20 (1), 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. The home's policy indicated that any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse is required to contact the MOHLTC (Director), disclosure to the resident's SDM, notify the Police, and immediately initiate a dignified and respectful investigation of the alleged, suspected or witnessed abuse. The policy was not followed on four occasions.

According to O. Reg 79/10, s. 54, every licensee shall ensure steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions. Resident #035 had a history of specific responsive behaviours towards other residents, however, their plan of care did not offer interventions such as increased monitoring or restricted areas, to minimize the risk of altercations and potential harmful interactions between residents. [s. 19. (1)]

Additional Required Actions:

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

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Inspector #603 reviewed resident #036's progress notes which revealed that on a certain date, they became upset and started to cry when resident #035 who had a history of specific responsive behaviours, touched them. The staff informed resident #035 that their behaviour was inappropriate and redirected them away from resident #036. The staff apologized to resident #036 for resident #035's behaviour and reassurance was provided.

The progress notes also indicated that on another date, resident #035 approached resident #036 and proceeded to touch them inappropriately. A PSW who witnessed this act, proceeded to remove the "....aggressor" and brought them to a different area and informed the DOC of this incident.

An interview with the DOC revealed that this specific incident, was not investigated, reported to the Director, nor was it reported to resident #036's SDM, because the home did not consider it abuse. The DOC also explained that the home had not reported the other abuse to the Director or to the police, and had not done an investigation. The DOC could not explain why the incident of abuse that happened on that certain date was not investigated or reported.

A review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" revealed that any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse is required to contact the MOHLTC (Director), disclosure to the resident's SDM, notify the Police, and immediately initiate dignified and respectful investigation of the alleged, suspected or witnessed abuse. [s. 20. (1)]

2. Inspector #603 reviewed resident #035's progress notes which revealed a history of specific responsive behaviours towards other residents. Most recently, resident #025 was abused by resident #035 on two different dates.

An interview with the DOC revealed that the two different incidents, were not investigated, not reported to the Director, Police, or to resident #025's SDM, because the home did not consider these incidents as being abusive. [s. 20. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

During stage 1 of the Resident Quality Inspection, observations revealed that three residents were utilizing bed rails for either assistance or safety reasons. Inspector #603 reviewed the three resident's care plans and they clearly identified the need for bed rails.

An interview with the DOC revealed that where bed rails were used, the residents were assessed for the need of bed rails. However, they confirmed that the resident's individual bed systems were not evaluated once the bed rail need was determined. The DOC explained that the home was working towards this goal but it was yet to be implemented.

A memo from the Ministry of Health and Long-Term Care (MOHLTC) dated August 21, 2012, was sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes. This document references the 'Clinical Guidance for the Assessment and implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings' (CGA), as a prevailing practice for the assessing the use of bed rails. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 004 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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

During the inspection, Inspector #603 observed RPN #107 feeding resident #011 while standing beside them. RPN #107 was preoccupied by looking around in the dining room and was not engaged with the resident.

An interview with RPN #107 revealed that the home's expectation was for staff to sit on a stool beside the resident while feeding them. RPN #107 then explained that their role on that day was to supervise the dining services and not feed residents; however, they decided to start feeding resident #011.

Inspector interviewed Dietary Manager and Food Services Supervisor who confirmed that the home's expectation was to have staff feed residents while sitting and in this case, it was not done. [s. 73. (1) 10.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Inspector #627 reviewed resident #001's progress notes which revealed that the resident had sustained two falls on a specific date. The first fall occurred at 0200hrs when the resident was attempting to go the the bathroom and the second fall happened at 0900hrs when the resident was ambulating to the dining room for breakfast. A Scott Fall Risk Assessment completed on the same day, indicated the resident was at a high risk for falls. At that time, resident #001 was placed on the Falling Star/Leaf Flagging Program.

A review of the home's current Falls Management Policy revealed that residents in the program will be identified with a wrist band or visible clothing items designated by the home, an icon placed on their bedroom door and near their bed, and a flag on their chart. In addition to vigilance in consistent application of enhanced fall precautions, the flagged resident will be monitored frequently (every 15, 30, 45 or 60 minutes as needed) to ensure safety, assist with care needs and prevent unsafe transfers particularly at shift change, and they were to be enrolled in a scheduled

toileting program regardless of continence level.

An interview with resident #001 revealed that they felt embarrassed when they fell. They stated that they had been told by staff to call when they needed assistance when going to the bathroom.

Inspector #627 interviewed PSW #103 who stated that the resident was on the falling star program. The resident had a star above their bed and needed more frequent checks; however, increased checks were not documented. PSW #103 further explained that the resident toileted themself independently but was encouraged to ring for assistance.

An interview with the DOC revealed that there was no falling star on the resident's door or binder, as these were not available at this time. The DOC confirmed that monitoring frequency documentation should have been in Point of Care (POC) and was not. The DOC also confirmed that resident #001 should have been enrolled in a scheduled toileting program and was not. [s. 8. (1) (a),s. 8. (1) (b)]

2. Inspector #627 reviewed resident #002's progress notes which revealed that they were moved to a specific floor. Upon admission to this floor, the resident was deemed a high risk for falls as per the Morse Fall Risk Screen and at the time of the review, the resident's Scott Fall Risk Screen also indicated they had a risk for falls.

A review of the home's "Falls Management Program" revealed that "residents would be flagged if their Scott Fall risk Screen score would be equal or greater than seven". The purpose for the Falling Star/Leaf Program was to identify residents at high risk of falls or fall injuries and to clearly communicate to staff and other care team members standard interventions for reducing risk.

An interview with RN #104 confirmed that resident #002 was not part of the Falling Star/Leaf Program and should have been. [s. 8. (1) (a),s. 8. (1) (b)]

3. Inspector #603 interviewed resident #007 who revealed that they had lost at least one pair of pants in the last few days. These missing pants were reported to the nursing staff and the resident's family member had contacted the home regarding this concern.

The Inspector reviewed the resident's progress notes and on a certain date, the

resident's family member reported to staff that three pairs of pants had gone missing. At that time, the staff had placed a call to the laundry department to "keep an eye out for them".

A review of the home's policy titled "Missing Personal Clothing #HL-06-03-12", last updated on September 2015, revealed that once a complaint of missing clothing were received, the Registered Staff/Nurse In Charge were to notify laundry staff promptly, along with the necessary information to conduct a search for clothing in the laundry area.

According to the Support Services Manager, the laundry department denied being informed of these missing articles. The Support Services Manager, confirmed that there was a break in communication once the resident's family member reported the missing articles and the laundry department was not notified of the missing pants. The support Services Manager confirmed that the home's policy was not followed. [s. 8. (1) (b)]

4. Inspector #627 reviewed a Critical Incident Report (CI), submitted to the Director. The CI alleged resident to resident abuse. The CI indicated that resident #027 wandered in resident #030's room and struck resident #030.

A review of the home's "Responsive Behaviour Policy, #09-05-01," last revised, September, 2010, revealed that all staff were responsible for completing accurate documentation in the resident's health record and on the "Responsive Behaviour Record 'EO Responsive Behaviour Debrief Sept 2013", when behaviours were observed. The documentation should clearly describe:
a) Any identified triggers to the behaviour,
b) How the behaviour was displayed,
c) What was observed in the immediate surroundings,
d) What interventions were tried;

A review of the Responsive Behavior Record 'EO Responsive Behaviour Debrief Sept 2013', for resident #027 revealed that section 5, 'Frequency of Responsive Behaviour Episodes' and section 6, 'Actions Taken' were left blank.

During an interview with the Inspector, ADOC #121 confirmed that the Responsive Behaviour Record 'EO Responsive Behaviour Debrief, September 2013' assessment form for resident #027 should have been completed as indicated in the home's Responsive Behavior Policy. Section 5 and 6 were not completed and

should have been [s. 8. (1) (b)]

5. Inspector #627 reviewed a Critical Incident Report (CI) submitted to the Director. The CI indicated that a narcotic tablet went missing on a certain date.

A review of the home's investigation notes revealed that a medication count was completed, and it was discovered that a narcotic was missing. ADOC #125 was notified and an investigation was started.

An interview with RPN #131 revealed that the home's policy for counting controlled substances was to have the incoming and outgoing RPN count the quantity of narcotic remaining. This process was to confirm that the actual quantity was the same as the amount recorded on the "Shift Change Narcotic Count" sheet and the "Individual Monitored Medication Record".

A review of a written statement from RPN #134, indicated that they had not completed a narcotic count with RPN #133 as they had been called away to attend to a resident.

A review of the home's current "Shift Change Monitored Drug Count Policy" revealed that the two registered staff (leaving and arriving), together will count the actual quantity of medications remaining, record the date, time, quantity of medication, sign in the appropriate spaces on the "Shift Change Narcotic Count" form, and confirm actual quantity was the same as the amount recorded on the "Individual Monitored Medication Record" for prn, liquid, patches, and injectables.

An interview with ADOC #125 confirmed that the home's expectation was that a narcotic count was done at every shift change with the incoming and outgoing RPNs, as per policy, and this was not done. [s. 8. (1) (b)]

6. Inspector #620 conducted an observation of the home's drug storage areas. During the observation it was identified that drugs were being stored in refrigerators, within the medication rooms on five of the home's floors. All of the medications within the refrigerators were required to be stored at temperatures between two degrees Celsius and eight degrees Celsius. All of the refrigerators contained medications that were placed in the refrigerator door. The refrigerator on the fifth floor contained a narcotic locked storage box (which contained narcotics) that was mounted onto the refrigerator door.

A review of the homes policy titled "Medication Storage, Policy 3-4, subsection 2" was completed by the Inspector. Under the heading of, 'The Refrigerator' the policy advised staff, 'not to store medications in the fridge door because the temperatures are not consistently in range'.

An interview with ADOC #125 confirmed that the home's policy stated that medications were not to be stored in the refrigerator doors because temperatures were not stable. The ADOC confirmed that medications were being stored in the refrigerator door, and should not have been. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's "Falls Management Policy", "Falls Management Program", "Missing Personal Clothing Policy #HL-06-03-12", "Responsive Behaviour Policy #09-05-01", "Shift Change Monitored Drug Count Policy", "Medication Storage Policy" put in place are complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the furnishings and equipment in the home were maintained in a safe condition and in a good state of repair.

Inspector #627 observed a Versa frame over the toilet seat of a resident's bathroom, to have a loose left arm that could be displaced by one foot in either direction. The Inspector was able to bend the arm back to a position that would be difficult for the resident to use as an aid.

An interview with RPN #102 revealed that the PSWs entered in the Maintenance Log Book any safety equipment that required maintenance. The RPN reported that the Maintenance department checked the book daily and completed the tasks required. Upon inspection of the Versa frame in the resident's bathroom, RPN #102 confirmed that the frame was unsafe for use.

A review of the maintenance book failed to reveal an entry for the Versa frame in this resident's bathroom.

An interview with Maintenance Staff #109 revealed that they had no preventive maintenance programs for Versa frames. The Maintenance Staff #109 explained that staff entered equipment concerns in the Maintenance Log Book which was reviewed at least daily. Once known, the equipment would then be fixed or changed. Upon inspection, Maintenance staff #109 confirmed that the Versa frame in resident #001's bathroom was unsafe and had to be changed. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the furnishings and equipment in the home are maintained in a safe condition and in a good stated of repair, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported was immediately investigated: (ii) Neglect of a resident by the licensee or staff.

Inspector #603 reviewed a complaint reported to the Director. The complaint alleged neglectful nursing care towards resident #016.

An interview with the resident's SDM revealed that on a specific date, they filed a formal complaint to the Administrator of the home and was told that since they were not the one responsible to deal with this complaint, they would transfer the information to the proper authorities. The SDM never heard from this person.

An interview with the DOC revealed that they had received the information from the Administrator and at that time (they did not remember the date), the resident was hospitalized and they forgot about it. The DOC confirmed that they failed to do an investigation into the complaint and there was no documentation available.

A review of the home's policy titled "Complaints #09-04-06" revealed that the home will respond to complaints whether they are written or verbal, in a timely manner. [s. 23. (1) (a)]

2. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported was immediately investigated: (i) Abuse of a resident by anyone.

Inspector #603 reviewed resident #036's progress notes which revealed that on a certain date, a fellow resident abused resident #036.

An interview with the DOC revealed that resident #035 had abused resident #036 on that specific date, and explained that they had relocated resident #035 to a different floor, in order to prevent this from happening again. The DOC also reported that the home had not done an investigation nor had they reported this incident to the Director. [s. 23. (1) (a)]

3. Inspector #603 reviewed resident #035's progress notes which revealed a history of specific responsive behaviours towards other residents. Most recently, resident #035 had abused resident #025 on two specific dates.

An interview with the DOC revealed that these two incidents were not investigated, not reported to the Director, Police, or to resident #025's Substitute Decision Maker (SDM), because the home did not consider these incidents as abuse.

A review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" revealed that any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse is required to contact the MOHLTC (Director), disclosure to the resident's Substitute Decision Maker, notify the Police, and immediately initiate a dignified and respectful investigation of the alleged, suspected or witnessed abuse. [s. 23. (1) (a)]

4. The licensee has failed to ensure that appropriate action was taken in response to every such incident.

Inspector #603 reviewed resident #035's progress notes which revealed a history of specific responsive behaviours towards different residents. The most recent specific responsive behaviour happened in the dining room. A PSW witnessed resident #035 inappropriately touch resident #025. Resident #035 was removed from the situation and told that their behaviour was inappropriate and that if they did this again, the police would be called. On another date, resident #035 was found inappropriately touching resident #025 in the dining room. Resident #035 was told to keep their hand to themself and was redirected out of the dining room.

A review of resident #035's care plan revealed that if resident #035 was displaying specific responsive behaviours towards certain residents, the staff were to separate resident #035 and certain residents, and if they experienced an increase in specific responsive behaviours towards them, resident #035 was to be reminded about respect and decency. There was no intervention to try and prevent specific responsive behaviours such as hightened monitoring, restricted areas, or keep resident away from certain residents.

An interview with the DOC revealed that the two specific incidents, the staff were focusing more on resident #035's "behaviours" and not on the reportability of the abuse. The DOC also explained that since the home simply assumed that resident #025 had consented to the specific behaviours, the home failed to ensure appropriate action was taken with each incident. [s. 23. (1) (b)]

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
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.

Inspector #620 reviewed a Critical Incident Report (CI) reported to the Director.

The CI alleged that PSW #117 had neglected to provide residents with the care that they required.

A review of the home's investigation notes revealed that on a certain date, seven staff had expressed that PSW #117 was not bathing residents as required in the plan of care, was providing false documentation with regard to care performed, and not answering call bells for residents that they were required to care for. The notes also described that RPN #118 became aware of the allegations when they overheard a gathering of PSW #117's colleagues discussing the level of care that PSW #117 had been providing.

RPN #118 sought the assistance of the charge RN #119 who conducted a meeting with all staff members involved. RN #119 collected information with regard to the allegations of neglect and forwarded an email to the DOC. RN #119 had not immediately reported the allegations to the Director.

An interview with the DOC revealed that they received the information regarding the allegations on a specific date, and concluded that the allegations were reportable because they represented an act of neglect. The DOC reported the allegation to the Director, a day after RN #119 became aware of the allegation of neglect.

Inspector #620 reviewed the home's current Zero Tolerances of Abuse and Neglect Policy. The policy stated that any person who had reasonable grounds to suspect that an act of abuse or neglect had occurred, were expected to immediately report the abuse to their immediate supervisor. Furthermore, registered staff were then expected to immediately report the actual/suspected incident of abuse/neglect to the Director.

Inspector #620 interviewed the DOC who confirmed that RN #119 had not reported the allegation of neglect to the Director as required by the home's policy on Zero Tolerance of Abuse and Neglect. The DOC stated that RN #119 had not recognized the allegation as an incident reportable to the Director. [s. 24. (1)]

2. The licensee has failed to ensure that any person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:

4. Misuse or misappropriation of a resident's money.

Inspector #620 reviewed a Critical Incident Report (CI) reported to the Director. The CI described a suspicion of abuse committed toward resident #032 by their Power of Attorney (POA). The CI revealed that a staff member became aware of the suspected abuse on a certain date, and reported the suspicion on the same day to the home's Administrator.

On a certain date, the Administrator suspected that resident #032 had been the victim of abuse and requested one staff member to notify the Greater Sudbury Police Service (GSPS). The Administrator notified the Director of the suspicion one day later.

Inspector #620 interviewed the Administrator who confirmed that they became aware of the suspected abuse on a specific day. The Administrator confirmed that they had not reported the suspicion of abuse until the next day. The Administrator stated that they should have reported the suspicion of abuse committed towards resident #032 by their POA immediately. [s. 24. (1)]

3. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may have occurred, immediately reported 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.

Inspector #603 interviewed RN #101 who explained that resident #035 had a history of specific responsive behaviours and for this reason, one of resident #035's medications had been increased. RN #101 explained that one of the most recent incidents of specific responsive behaviours happened when resident #035 inappropriately touched another resident.

A review of resident #035's progress notes revealed that on a certain date, they went over to resident #036 and proceeded to inappropriately touch them. A PSW who was providing morning care to other residents witnessed this act and proceeded to remove resident #035 from the situation. The progress notes also indicated that on a specific date, the DOC was informed of this incident and the DOC looked into transferring resident #035 to another floor.

An interview with the DOC revealed that the suspected abuse on a certain date,

happened between resident #035 and resident #036 and confirmed that they forgot to report this incident to the Director. [s. 24. (1)]

4. Inspector #603 reviewed a Critical Incident Report (CI) reported to the Director. The CI related to resident to resident abuse by resident #035 towards resident #034. According to the CI, the residents involved were immediately separated and the home started their investigation on the same day.

An interview with the DOC revealed that as soon as they were informed of the incident, they started their investigation; however, they did not report the CI until four days after the incident happened. [s. 24. (1)]

5. Inspector #603 reviewed resident #035's progress notes which revealed a history of specific responsive behaviours towards different residents. The progress notes indicated that resident #035 inappropriately touch resident #025's on two different days.

An interview with PSW #135 who was present at one of the incident, revealed that after this incident, resident #025 told them that they did not want this behaviour and stated, "I don't want them around here anymore".

Inspector interviewed the DOC who was surprised that resident #025 would have brought forward concerns about specific responsive behaviours towards them. The DOC explained that they were under the impression that resident #025 had consented to the behaviours as they were capable of making their own decisions and the home had no knowledge that resident #025 would protest this type of behaviour.

The DOC explained that the home had not reported the incidents between resident #025 and resident #035 to the Director, as the home did not see these incidents as abuse. [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 any person who has reasonable grounds to suspect that any of the following has occurred or may occur, 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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Inspector #603 reviewed a Critical Incident Report (CI) reported to the Director. The CI related to resident to resident abuse by resident #035 towards resident #034.

A review of resident #035's progress notes revealed that they had a history of abusing co-residents on six different dates.

A review of the home's "Introduction to Care Planning document" revealed that "a care plan should be individualized and specific to each resident. Every care plan must include the following criteria: Focus, Goal(s), and Interventions(s). Interventions are statements specifically outlining the course of action necessary to obtain the goal(s). They provide insight to staff on the requirements of care relating to each focus and must be specific to each resident in order to provide the most effective intervention".

A review of the resident's care plan identified a focus for specific responsive behaviours; however, there was no interventions to minimize the risk of altercations and potential harmful interactions between residents except for reactive actions once the behaviours were displayed. Furthermore, there was no heightened monitoring for specific responsive behaviours and the resident's care plan allowed for independent locomotion on and off the unit. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #11: 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 has failed to ensure that direct care staff were advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, required heightened monitoring because those behaviours posed a potential risk to the resident or others.

Inspector #603 reviewed a Critical Incident Report (CI) which was reported to the Director. The CI referred to resident to resident abuse by resident #035 towards resident #034.

A review of resident #035's progress notes revealed a history of multiple incidents of abuse towards different co-residents.

An interview with attending RN#101 revealed that resident #035 was known to have specific responsive behaviours and needed to be monitored more closely around certain areas.

An interview with RPN #126 who was caring for resident #035, revealed that they were not aware of the resident's specific responsive behaviours. RPN #126 explained that they had not looked at any of their assigned resident's care plans and had not listened to report at the beginning of their shift.

An interview with the DOC revealed that all staff were expected to review their assigned resident's care plan and shift report at the beginning of their shift to identify residents whose behaviours require heightened monitoring, because these behaviours may pose a potential risk to residents or others.

A review of the home's "Quality Protocol Responsive Behaviours" form identified that "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".

A review of the home's current "Responsive Behaviours Policy" indicated that all staff providing care to residents were required to be familiar with the resident plan of care, the specific interventions related to behaviours and be consistent in the application and implementation of these interventions. [s. 55. (b)]

Additional Required Actions:

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

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #603 reviewed resident #036's progress notes which revealed that on a certain date, resident #035 was seen touching resident #036 which made them upset.

On a certain date, a progress note revealed that resident #036's SDM called the DOC to discuss the incident. The DOC explained to the SDM that since the incident was not sexual in nature, the home did not report it to them.

An interview with the DOC revealed that the resident's SDM had not been notified of the incident as it was not considered sexual abuse. There was no consideration for emotional abuse.

The Long-Term Care Homes Act, 2007, defines emotional abuse as any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences. [s. 97. (1) (a)]

2. Inspector #603 reviewed resident #035's progress notes which revealed a history of specific responsive behaviours towards different residents. The most recent specific responsive behaviour happened on a certain date, when resident #035 was in the dining room. A PSW witnessed resident #035 inappropriately touch resident #025. Resident #035 was removed from the situation and told that their behaviour was inappropriate and that if they did this again, the police would be called. On another date, resident #035 was found inappropriately touching resident #025 while in the dining room. Resident #035's was told to keep their hands to themself and was redirected out of the dining room.

An interview with the DOC revealed that in these two incidences of abuse, the SDM was not made aware and should have been. [s. 97. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's SDM and any other person specified by the resident are immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health and well-being, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

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

Inspector #603 reviewed resident #036's progress notes which revealed that on a certain date, resident #035 approached resident #036 and proceeded to inappropriately touch them. A PSW who witnessed this act, removed resident #035, brought them to the dining room, and informed the DOC of the incident.

An interview with the DOC revealed that resident #035 abused resident #036 and the home had not reported this incident to the Director or to the Police. [s. 98.]

2. Inspector #603 reviewed resident #035's progress notes which revealed a history of specific responsive behaviours towards different residents. The most recent specific responsive behaviour happened when resident #035 inappropriately touched resident #025.

During an interview with the DOC, they explained that the Police were not notified as the home did not see these incidents as abuse. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the appropriate police force 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, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident bedroom occupied by more than one resident had sufficient privacy curtains to provide privacy.

During the inspection, Inspector #627 noted that resident #002's privacy curtain could not be closed when the ceiling lift was being used, as the track for the ceiling lift was behind the curtain, thus preventing the curtain from being closed when the lift was used. Resident #002 was in a room shared with four residents. Furthermore, the resident directly in front of resident #002 did not have a privacy curtain in place.

Inspector #627 interviewed RPN #102 who confirmed that the placement of the lift tract behind the privacy curtain prevented the curtain from being closed when the mechanical lift was used. RPN #102 confirmed that the curtain needed to be behind the lift track and a curtain needed to be added for the resident in the next bed. [s. 13.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication system that was available in every area accessible by residents.

During the inspection, Inspector #627 observed a common area bathroom and noted that the pull cord for the call bell was not attached to the call bell. It was wrapped around the bottom of the bell and was not functional.

During an interview with the Maintenance Staff #109, they confirmed the call bell pull cord would have to be changed as it had been pulled out out of the wall and was not functional. [s. 17. (1) (e)]

WN #16: 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,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent, had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that the plan was implemented.

During stage 1 of the Resident Quality Inspection (RQI), resident #004 was identified as being in a room which had a strong urine odour. Further observation by Inspector #620 revealed that the odour was emanating from an adjacent room.

Inspector #620 interviewed RN #101 who indicated that a certain resident was the source of the odour of urine.

Inspector #620 conducted observations of a certain room on seven occasions between two days. On all occasions, the room had a strong odour of urine.

Inspector #620 reviewed the home's Continence Management Program titled "RESI-10-04-01" last revised, November 2013. The Program advised that all residents who were incontinent would have a plan of care that was reflective of their functional status, personal and healthcare needs and appropriate interventions such as scheduled toileting, toileting routines, bladder training (as appropriate).

A review of resident #009's plan of care revealed that there were no interventions in place to manage the resident's continence care.

Inspector #620 interviewed the DOC who confirmed that resident #009's plan of care did not provide sufficient interventions to address the resident's incontinence; nor had it advised staff on how to manage the resident's incontinence, and should have. [s. 51. (2) (b)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items were offered and available at each meal and snack.

On a certain date, Inspector #603 observed the dining services on a certain floor. The menu consisted of:

-Chicken Barley Soup
-Monte Christo Sandwich
-Carrot/Apple salad
-Mandarine Orange
or
-Steak and Mushroom pot pie
-Winter Vegetable
-Orange Sherbert.

Inspector observed resident #012, #013, and #014 request a steak and mushroom pot pie. All three residents were on a specific texture diet and were denied the steak and mushroom pot pie as there was none left, and were given something else.

An interview with Dietary Aid #108 who was preparing the meals, confirmed that they had run out of a specific texture steak and mushroom pot pie. Dietary Aid #108 explained that normally, they will call other units to see if they would have anymore food to spare, but in this case they decided to give the residents specific textured sandwiches. After the interview, a staff member called the kitchen to see if more specific textured steak and mushroom pot pie were available and approximately 10 minutes later, one single portion was brought to the unit; however, the residents were already eating their specific textured sandwiches.

An interview with Food Services Supervisor, revealed that the home does run out of certain foods at times and confirmed that it was difficult to gage the amount of food required. The Food Services Supervisor explained that different factors such as colder or warmer weather may impede the amount needed. The food Services Supervisor explained that when they and the Dietary Manager become aware of the lack of food, they would do their best to bring some from other floors. In this case, it was too late. [s. 71. (4)]

Issued on this 30 day of August 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SYLVIE LAVICTOIRE (603) - (A1)

Inspection No. / No de l'inspection : 2016_391603_0007 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 008916-16 (A1)

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

Report Date(s) / Date(s) du Rapport : Aug 30, 2016;(A1)

Licensee / Titulaire de permis :
EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700,
MARKHAM, ON, L3R-9W2

LTC Home / Foyer de SLD :
EXTENDICARE YORK
333 YORK STREET, SUDBURY, ON, P3E-5J3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Tracy Lamirande

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

Ministère 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

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_320612_0004, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall develop and implement a process to ensure that the care set out in the plan of care for resident #033, is provided to the resident as specified in the plan.

Grounds / Motifs :

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

Inspector #627 reviewed a Critical Incident Report (CI) submitted to the Director. The CI alleged staff to resident abuse; whereby, PSW #122 and RPN #123 inappropriately transferred resident #033. Resident #033 had reported the incident to their family member, who reported the information to ADOC #125.

Inspector #627 reviewed the home's investigation notes, which revealed a written interview with PSW #122 who stated that they had transferred resident #033 with a two staff assist (one staff member on each side of the resident) with RPN #123, stood resident #033 up and pivoted them. The same technique was utilized when they returned the resident to bed.

Inspector #627 reviewed the home's progress notes, which revealed that as per the

request of the DOC, a resident head to toe assessment was completed with no injury identified.

Inspector #627 reviewed resident #033's care plan at the time of the incident, which revealed a focus for "Transfer r/t physical limitation" and the interventions included a specific mechanical lift with two staff.

Inspector #627 interviewed PSW #122 who explained that it was the home's expectation that a two person transfer should be done with a specific mechanical lift. PSW #122 also explained that this type of transfer was to ensure resident and staff safety. PSW #122 further explained that RPN #123 had assisted them to transfer resident #033 by standing and pivoting the resident. PSW #122 confirmed that they had not used a specific mechanical lift due to a time constraint. PSW #122 confirmed that a specific mechanical lift should have been used.

An interview with the ADOC #125 confirmed that the care set out in the plan of care was not provided to the resident, as specified in the plan of care and should have been.

LTCHA, 2007 S.O. 2007, s. 6. (7) was issued previously as WN and CO during Inspection #2016_320612_0004 on January 25, 2016, a WN and CO during Inspection #2015_391603_0024 on July 20, 2015, a WN and VPC during Inspection #2014_331595_0010 on October 6, 2014.

The decision to issue this compliance order was based on the scope which was isolated, the severity which indicated minimal harm or potential for actual harm and the compliance history which despite previous non-compliance (NC), NC continues with this area of the legislation.
(627)

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

Aug 17, 2016

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit, and implement a plan for ensuring that every resident in the home, is protected from abuse by anyone. The plan shall address, but is not limited to the following:

1. That the plan of care for resident #035 is reviewed and updated with the identification of the sexually abusive behaviour triggers, strategies taken to mitigate risks associated with sexually abusive behaviours, including psychological, pharmaceutical, behavioural, physical interventions, and interventions to ensure other residents are protected from abuse.
2. Re-training for all staff specific to the identification, management, monitoring, and reporting of any alleged or suspected abuse as per LTCHA, 2007.
3. Retraining for all staff on the home's policy to promote zero tolerance of abuse and neglect of residents.
4. Continuous monitoring of the above steps to ensure compliance with the LTCHA, 2007 and O. reg 79/10.

This plan shall be submitted in writing to Sylvie Lavictoire, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564 3133 or email sylvie.lavictoire@ontario.ca. This plan must be submitted by August 17, 2016.

Grounds / Motifs :

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

Inspector #603 reviewed a Critical Incident Report (CI) submitted to the Director. The CI indicated that resident #034 reported to registered staff that resident #035 woke them up and displayed specific responsive behaviours.

A review of resident #035's care plan revealed that they displayed specific responsive behaviours. The care plan offered no interventions such as increased monitoring or restricted areas, to minimize the risk of altercations and potential harmful interactions between residents.

A review of resident #035's progress notes revealed a history of specific responsive behaviours toward other residents and staff members. During a one year span, the resident displayed fourteen specific responsive behaviours. The progress notes also indicated that a third party had been involved with resident #035 for some time and because of specific responsive behaviours.

During a review of resident #035's health care record, the Inspector noted additional specific responsive behaviours that occurred towards two other residents (#036 and #025) by resident #035.

1) A review of resident #036's progress notes revealed that on a certain date, resident #035 was seen touching resident #036, which made them upset and caused them to cry. RPN #111 addressed resident #035 about their inappropriate behaviour and redirected them away from the scene. Another progress note revealed a second incident where resident #035 approached resident #036 and proceeded to touch them inappropriately. According to the progress note, the PSW who witnessed this act, proceeded to remove resident #035 and brought them to a different area.

O. Reg. 79/10, s. 2 (1) defines emotional abuse between residents as any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, action, behaviour or remarks understands and appreciates their consequences.

A review of resident #036's care plan revealed that there were no interventions to keep resident #036 safe from resident #035 as they had been a victim previously.

An interview with the DOC confirmed that resident #035 had a history of exhibiting abusive behaviours. The DOC explained that in most of these incidents of inappropriate behaviours involving resident #035, the staff focused on their responsive behaviours and not on abuse. The DOC confirmed that the incident of abuse that occurred on a certain date, where resident #035 touched resident #036 was not investigated, reported to the Director, nor was it reported to resident #036's Substitute Decision Maker (SDM), because the home did not consider this abuse. The DOC also explained that the home had not reported the second incident of abuse by resident #035 to resident #036, to the Director or to the police, and had not done an investigation. The DOC could not explain why the second incident of abuse was not investigated or reported.

A review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" revealed that any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse is required to contact the MOHLTC (Director), disclosure to the resident's SDM, notify the Police, and immediately initiate a dignified and respectful investigation of the alleged, suspected or witnessed abuse.

An interview with the Administrator revealed that the home recognized that they had addressed the second incident incorrectly and failed to view this as abuse.

2) A review of resident #035's progress notes revealed a history of specific responsive behaviours towards staff and residents. On a certain date, resident #035 was found inappropriately touching resident #025. Resident #035 was told to keep their hands to themself and was redirected out of the area. On another date, a second incident occurred where PSW witnessed resident #035 inappropriately touching #025. Resident #035 was removed from the situation and told that their behaviour was inappropriate and that if they did this again, the police would be called.

O. Reg 79/10, s. 2 (1) defines sexual abuse as any non-consensual touching, behaviour or remarks or a sexual nature or sexual exploitation by anyone.

An interview with PSW #135 who was present at the second incident, revealed that after this incident resident #025 told them that they did not want this behaviour and stated: "I don't want them around here anymore". PSW #135 told resident #025 that this type of behaviour was unacceptable and that they had informed resident #035 that it was not appropriate. According to PSW #135, this conversation seemed to satisfy resident #025. PSW #135 also explained that for some unknown reason, resident #035 seemed to target resident #025 with specific responsive behaviours. Inspector asked what had been done to prevent such interactions between resident #035 and #025, and PSW #135 explained that there was no heightened monitoring for resident #035's specific responsive behaviours; however, the staff were aware that as soon as resident #035 finished their meals, the staff facilitated the resident's exit out of the specific area.

Inspector #620 interviewed resident #025 regarding the incident of alleged abuse. The Inspector asked the resident whether they recalled an incident involving a certain resident. Resident #025 confirmed that another resident inappropriately

touched them and that it was witnessed by a staff member. The resident was unable to remember what the resident's name or the name of the staff member who witnessed the event. The resident stated that the staff member said that they (the staff member) needed to stop what had occurred. The resident recalled being offended by the other resident's actions and they were unsure why the resident did it. Resident #025 stated that they saw the offending resident all the time and that they had inappropriately touched them on many occasions. The resident stated that they tried to get away but that sometimes the resident approached them from behind. Resident #025 stated that they got mad and told the resident to, "stop it" and to, "get away." The resident also stated that the offending resident often tried to put their hands on resident #025's shoulder and that they pushed them away. The resident stated that they did not like the offending resident and did not like being touched by them.

Inspector #603 interviewed the DOC who was surprised that resident #025 would have brought forward concerns about specific responsive behaviours towards them, by resident #035. The DOC explained that they were under the impression that resident #025 consented to the specific responsive behaviours as they were capable of making their own decisions. The DOC confirmed that there had been no formal assessment completed to determine if resident #025 had consented to the specific responsive behaviours by resident #035.

Inspector reviewed resident #025's care plan which revealed that the resident was unable to make decisions for themself. A review of the resident's most recent MDS assessment revealed that they were not independent for daily decision making.

A final interview with the DOC revealed that the home had incorrectly assumed that resident #025 had consented to resident #035's specific responsive behaviours and explained that the incidents on two certain dates, were not investigated, not reported to the Director, Police, or to resident #025's SDM, because the home did not consider these incidents as being abusive.

A review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" revealed that any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse is required to contact the MOHLTC (Director), disclosure to the resident's SDM, notify the Police, and immediately initiate a dignified and respectful investigation of the alleged, suspected or witnessed abuse.

According to the LTCHA 2007, s. 23, every licensee of a long-term care home shall ensure that, every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated. Two incidents of alleged abuse involving resident #035 toward resident #036 on two certain dates, were not investigated. In addition, two incidents of alleged abuse involving resident #035 toward resident #025 on two other dates, were not investigated.

According to the LTCHA, 2007, s.24 (1) 2, 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, immediately report the suspicion and the information upon with it is based to the Director. Two incidents of alleged abuse involving resident #035 toward resident #036 on two certain dates, were not reported to the Director. In addition, two incidents of alleged abuse involving resident #035 toward resident #025 on two other dates, were not reported to the Director.

According to the LTCHA, 2007, r.97 (1) (a), the resident's SDM and any other person specified by the resident are to be immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being. Resident #036's SDM was not notified of an alleged incident of abuse involving resident #035 on a certain date. In addition, resident #025's SDM was not notified of two alleged incidents of abuse involving resident #035, on two other certain dates.

According to the LTCHA, 2007, s. 20 (1), 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. The home's policy indicated that any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse is required to contact the MOHLTC (Director), disclosure to the resident's SDM, notify the Police, and immediately initiate a dignified and respectful investigation of the alleged, suspected or witnessed abuse. The policy was not followed on four occasions.

According to O. Reg 79/10, s. 54, every licensee shall ensure steps are taken to minimize the risk of altercations and potentially harmful interactions between and

among residents, including identifying and implementing interventions. Resident #035 had a history of specific responsive behaviours towards other residents, however, their plan of care did not offer interventions such as increased monitoring or restricted areas, to minimize the risk of altercations and potential harmful interactions between residents.

LTCHA, 2007 S.O. 2007, s. 19. (1) was issued previously as WN and VPC during Inspection # 2016_282543_0002 on January 25, 2016.

The decision to issue this compliance order was based on the scope which involved a pattern, the severity which indicated actual harm, and the compliance history which despite previous non-compliance (NC), NC continues with this area of the legislation. (603)

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

Sep 30, 2016(A1)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

The licensee shall re-educate all staff and others who provide direct care to the residents, on the home's written Zero Tolerance of Abuse and Neglect Policy. The re-education must include:
1. Monitoring residents who are at risk or who display any abusive behaviours, including sexually abusive behaviours.
2. Reporting alleged, suspected, or witnessed resident abuse.
3. Contacting the MOHLTC, Substitute Decision Maker, and the police of alleged, suspected, and witnessed abuse.

Grounds / Motifs :

1. Inspector #603 reviewed resident #035's progress notes which revealed a history of specific responsive behaviours towards other residents. Most recently, resident #025 was abused by resident #035 on two different dates.

An interview with the DOC revealed that the two different incidents, were not investigated, not reported to the Director, Police, or to resident #025's SDM, because the home did not consider these incidents as being abusive. (603)

2. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Inspector #603 reviewed resident #036's progress notes which revealed that on a certain date, they became upset and started to cry when resident #035 who had a history of specific responsive behaviours, touched them. The staff informed resident #035 that their behaviour was inappropriate and redirected them away from resident #036. The staff apologized to resident #036 for resident #035's behaviour and reassurance was provided.

The progress notes also indicated that on another date, resident #035 approached resident #036 and proceeded to touch them inappropriately. A PSW who witnessed this act, proceeded to remove the "....aggressor" and brought them to a different area and informed the DOC of this incident.

An interview with the DOC revealed that this specific incident, was not investigated,

reported to the Director, nor was it reported to resident #036's SDM, because the home did not consider it abuse. The DOC also explained that the home had not reported the other abuse to the Director or to the police, and had not done an investigation. The DOC could not explain why the incident of abuse that happened on that certain date was not investigated or reported.

A review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" revealed that any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse is required to contact the MOHLTC (Director), disclosure to the resident's SDM, notify the Police, and immediately initiate dignified and respectful investigation of the alleged, suspected or witnessed abuse.

LTCHA, 2007 S.O. 2007, s. 20 (1) was issued previously as WN and CO during Inspection #2015_391603_0024 on July 20, 2015, a WN and VPC during Inspection #2015_320612_0006 on April 20, 2015, and a WN during Inspection #2014_331595_0010 on October 6, 2014.

The decision to issue this compliance order was based on the scope which involved a pattern, the severity which indicated actual harm, and the compliance history which despite previous non-compliance (NC), NC continues with this area of the legislation. (603)

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

Sep 30, 2016(A1)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall develop and implement the following:

1. A process to ensure that where bed rails are used for any reason, the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

2. The licensee shall refer to the Health Canada guidance document "Clinical Guidance for the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings" as evidence-based practices.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

During stage 1 of the Resident Quality Inspection, observations revealed that three residents were utilizing bed rails for either assistance or safety reasons. Inspector #603 reviewed the three resident's care plans and they clearly identified the need for bed rails.

An interview with the DOC revealed that where bed rails were used, the residents were assessed for the need of bed rails. However, they confirmed that the resident's individual bed systems were not evaluated once the bed rail need was determined. The DOC explained that the home was working towards this goal but it was yet to be implemented.

A memo from the Ministry of Health and Long-Term Care (MOHLTC) dated August 21, 2012, was sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes. This document references the 'Clinical Guidance for the Assessment and implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings' (CGA), as a prevailing practice for the assessing the use of bed rails.

The decision to issue this compliance order was based on the scope which was widespread and the severity which indicated a potential for actual harm. There was no history of non compliance in this part of the legislation.
(603)

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

Aug 31, 2016

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Order / Ordre :

The licensee shall prepare and implement a plan that will ensure proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

Grounds / Motifs :

1. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

During the inspection, Inspector #603 observed RPN #107 feeding resident #011 while standing beside them. RPN #107 was preoccupied by looking around in the dining room and was not engaged with the resident.

An interview with RPN #107 revealed that the home's expectation was for staff to sit on a stool beside the resident while feeding them. RPN #107 then explained that their role on that day was to supervise the dining services and not feed residents; however, they decided to start feeding resident #011.

Inspector interviewed Dietary Manager and Food Services Supervisor who confirmed that the home's expectation was to have staff feed residents while sitting and in this case, it was not done.

LTCHA, 2007 S.O. 2007, r. 73. (1) 10. was issued previously as WN and VPC during Inspection #2015_391603_0024 on July 20, 2015 and a WN and VPC during Inspection #2014_331595_0010 on October 6, 2014.

The decision to issue this compliance order was based on the scope which was isolated, the severity which indicated a potential for actual harm and the compliance history which despite previous non-compliance (NC), NC continues with this area of the legislation. (603)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Aug 17, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 30 day of August 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SYLVIE LAVICTOIRE - (A1)

Service Area Office /
Bureau régional de services : Sudbury