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
Jan 06, 2017;	2016_435621_0012 (A2)	017970-16	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX 3251 THUNDER BAY ON P7B 5G7

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

HOGARTH RIVERVIEW MANOR
300 LILLIE STREET THUNDER BAY ON P7C 4Y7

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

JULIE KUORIKOSKI (621) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

A finding for s.6(9)1 for a complaint received by the MOHLTC on June 14 and June 21, 2016, related to resident #025's missed baths over a 10 day period in June 2016 was found missing from this report on the final served version. The addition of this finding can be found on page 23 as 8.0 within the amended licensee report #2016_435621_0012 A2

Issued on this 6 day of January 2017 (A2)

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

Original report signed by the inspector.

Ontario

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

JULIE KUORIKOSKI (621) - (A2)

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): July 4 - 8, 11 - 15, and 18 - 20, 2016.

Additional intakes completed during this inspection included:

One intake related to follow up of past due compliance order #001, Long-Term Care Homes Act (LTCHA) s.24(1); another intake related to follow up of past due compliance order #001, LTCHA s.3(1); and a final intake related to follow up of past due compliance order #001, O.Regulation 79/10, s.74(2).

Two intakes related to complaints of alleged resident neglect;

Four intakes related to critical incidents (CI) the home submitted regarding staff to resident abuse and neglect;

Seven intakes related to CIs the home submitted regarding resident to resident abuse; and

Two intakes related to CIs the home submitted regarding medication management.

During the course of the inspection, the inspector(s) spoke with the Vice President of Seniors' Health/Administrator, Acting Director of Care (Acting DOC), Manager of Regional Behavioral Health Services, Managers for floors one through seven, Nutrition Manager (NM), Food Service Supervisors (FSS), Maintenance Supervisor, Client Care Coordinator, Therapeutic Recreationists, Resident Engagement Coordinator, Registered Dietitians (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides, family members and residents.

Observations were made of resident care areas, provision of care and services to residents, as well as staff to resident and resident to resident interactions. The home health care records for several residents, and personnel files of a number of staff were reviewed, along with relevant policies, procedures and programs of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

- **19 WN(s)**
- **12 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 24. (1)	CO #001	2016_246196_0006	617
LTCHA, 2007 s. 3. (1)	CO #001	2016_246196_0005	613
O.Reg 79/10 s. 74. (2)	CO #001	2016_246196_0007	621

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the protection of residents from abuse by anyone.

Under O.Regulation 79/10, physical abuse is defined as "the use of physical force by a resident that causes physical injury to another resident".

Inspector #621 reviewed a Critical Incident Report (CI) that was submitted to the Director for an incident of resident to resident physical abuse resulting in injury, which occurred in the summer of 2016. It was documented that resident #020 and #019 were separated and PSW #166 then reported the incident to RN #124, who assessed resident #019's injury and initiated the incident reporting process.

On review of resident #020's progress notes over a six month period between January and July 2016, Inspector #621 identified 25 incidents of responsive behaviours.

Of the 25 incidents, four were specific to interactions between resident #020 and #019 that occurred on three dates in June and July 2016. In all four incidents, resident #020 was identified as the aggressor, and in two of these incidents which occurred during June and July 2016, injury to resident #019 was documented with subsequent critical incident reports submitted to the Director.

During an interview in July 2016, PSW #148 and RN #124 reported to the Inspector that resident #020 exhibited responsive behaviours, and resident #019 was a trigger for resident #020. PSW #148 and RN #124 indicated that they utilized strategies to mitigate responsive behaviours for resident #020.

When Inspector #621 asked PSW #148 about what forms of documentation were kept of staff monitoring resident #020's responsive behaviours, it was reported that they were not aware of any formal documentation except when an incident occurred which would be added to the progress notes.

A review of the home's policy titled "Responsive Behaviours Program - LTC 3-50", last revised March 2016, referred to an accompanying document titled "Long-Term Care Responsive Behaviours Toolkit", last revised May 2016, which identified that a key aspect of resident care included prevention or minimization of situations in which a resident exhibited responsive behaviours. As part of the prevention strategies the toolkit identified that assessment included utilization of screening tools such as the Dementia Observation System (DOS), and documentation of observations was to be found in the resident chart and progress notes.

On a specific date in July 2016, Inspector #621 reviewed resident #020's

documentation and identified DOS charting had occurred for the period of one week in July 2016, but the DOS record was incomplete. Additionally, no DOS records were found between January and July 2016, when 25 incidents of responsive behaviours were identified by staff.

During an interview in July 2016, RN #124 identified that DOS charting could be initiated by staff at any time, and that a specific request for DOS charting for resident #020 was made by Manager #123 for a one week period in July 2016.

On review of resident #020's documentation, RN #124 reported that a DOS was initiated for one week in July 2016, but identified to the Inspector that the DOS record was incomplete. Additionally, RN #124 identified that no DOS charting had been completed as part of the home's monitoring of resident #020's responsive behaviours between January and July 2016 when 25 incidents of responsive behaviors were documented to have occurred.

During an interview on July 18, 2016, Manager #123 identified that it was their expectation that as part of responsive behaviour monitoring of residents, that DOS charting of residents was to be completed for those residents, including resident #020 with known responsive behaviours.

On review of resident #020's documentation, Manager #123 confirmed that DOS charting was not completed as part of monitoring this resident's responsive behaviours in spite of 25 incidents identified in the documentation since the first quarter of 2016. Of those 25 incidents, four occurred between resident #020 and #019 between June and July 2016, and two of those four incidents resulted in injury. Additionally, Manager #123 identified that when DOS charting was initiated to monitor resident #020's responsive behaviours for one week in July 2016, it was found incomplete.

Inspector #621 reviewed resident #020's care plan and identified that there were no care plan updates after May 2016, in spite of there being two critical incidents reported to the Director for responsive behaviours between resident #020 and #019 causing injury to resident #019.

On review of care planning for resident #020, Manager #123 identified that the most current written care plan for resident #020 was dated on a specific date in May 2016. Consequently, Manager #123 identified that in addition to lack of documented monitoring, care planning for responsive behaviour management for

this resident had not been updated at any time after the two critical incident reports were submitted in June and July 2016 between resident #020 and #019, and confirmed that the home failed to protect resident #019 from further incidents of abuse following the June 2016 incident.

Additionally, the home failed to protect resident #019 from abuse by resident #020 as evidenced by non-compliance identified during this inspection related to:
WN #2, LTCHA, 2007, O. Reg. 79/10, s. 53 (4) where the home failed to ensure that for resident #020's demonstrated responsive behaviours, strategies were developed and implemented to respond to those behaviours; and
WN #7, LTCHA, 2007, O. Reg. 79/10, s.20 (1) where the home failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with. [s.19.(1)]

2. Under O.Reg 79/10, sexual abuse is defined as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

Inspector #621 reviewed a CI report that was submitted to the Director on a specific date in April 2016, for an incident of resident to resident sexual abuse.

During a review of the progress notes for resident #030 over a six month period between January and July 2016, Inspector #621 identified nine additional incidents of sexual responsive behaviours between resident #030 and co-residents. Of the nine incidents, six occurred prior to the April 2016, CI which was reported to the Director, and the remaining three incidents occurred thereafter.

During an interview in July 2016, RN #124 reported to Inspector #621 that resident #030 had demonstrated sexual responsive behaviours since their admission to the home. RN #124 also reported to the Inspector that staff utilized strategies to mitigate resident #030's responsive behaviours, including re-direction of resident away from vulnerable residents, and that documentation of these strategies would be found in this resident's care plan in paper copy on their chart, as well as in their electronic health record. When the Inspector inquired if there had been referral to outside resources RN #124 indicated that there was no formal referral process but starting on a specific date in April 2016 the Psychogeriatric Resource Consultant (PRC) began providing services to the Behavioral Support Unit (BSU) and staff utilized one page handouts from the PRC that offered strategies on how to manage this resident's behaviours.

Inspector completed a review of resident #030's plan of care, including their chart and written care plan and found no strategies care planned for managing this resident's sexual responsive behaviours.

RN #124 reviewed the most current care plan dated in July 2016, and reported that both the hard copy and electronic version of resident #030's care plan did not include any documented strategies for managing this resident's responsive behaviours. Additionally they identified there was no information on responsive behaviour strategies from PRC on the chart for staff to refer to.

During an interview on in July 2016 with the PRC, they identified that they were a contract service provider and started in their role on a specific date in April 2016. They indicated that they had not yet provided any documented strategies for managing resident #030's responsive behaviours as part of this resident's plan of care.

During a review of the home's policy titled, "Zero Tolerance of Abuse and Neglect of Residents - Reporting and Notifications about Incidents of Abuse and Neglect – LTC 5-51", last revised February 2016, identified that staff members who had witnessed or suspected alleged incidents of resident abuse or neglect were to immediately report to the Director/designate, and/or the VP Seniors' Health, who would then notify the Ministry of Health and Long-Term Care (MOHLTC) by phone and initiate an investigation.

During an interview in July 2016, Manager #123 identified to Inspector #621 that it was their expectation that any suspected incidents of abuse be reported by staff as per the home's policy, which included forwarding an email notification of the incident to the Manager, who would to then report it to the MOHLTC.

Manager #123 reviewed the documentation for resident #030 and confirmed to the Inspector that the sexual inappropriate behaviours as reported by staff from documentation between January and July 2016, constituted suspected sexual abuse and that the incidents were not reported by staff as per home's policy. Additionally, Manager #123 reviewed resident #030's most current written plan of care and confirmed that care planning for sexual responsive behaviour management had not been completed.

Additionally, the home failed to protect residents from abuse by resident #030 as

evidenced by non-compliance identified during this inspection related to:
WN #2, LTCHA, 2007, O. Reg. 79/10, s. 53 (4) where the home failed to ensure that for resident #030's demonstrated sexual responsive behaviours, strategies were developed and implemented to respond to those behaviours;
WN #3, LTCHA, 2007, s.6(1)(a) where the home failed to ensure that there was a written plan of care that set out the planned care for resident #030's sexual responsive behaviours; and
WN #7, LTCHA, 2007, O. Reg. 79/10, s.20 (1) where the home failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with. [s.19.(1)]

3. A CI report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home related to an incident of resident to resident physical abuse that occurred in June 2016.

The Inspector reviewed documentation in resident #015's electronic health record related to incidents of responsive behaviours between their admission date and a specific date in June 2016, when a physical altercation with resident #015 resulted in abuse of co-resident #016.

The first incident of resident #015's responsive behaviours was documented in March 2016, followed by five additional incident notes that identified resident #015's becoming physically responsive with unidentified co-residents.

The Inspector reviewed resident #015's admission care plan dated from February 2016, and the most current care plan dated in May 2016, related to responsive behaviours. Neither care plan included a responsive behaviour focus or interventions to manage the behaviours. On further review, a 24 hour care plan from February 2016, identified the resident's behaviours as verbal and physical aggression.

Additionally, the Inspector reviewed two consultation notes dated from May 2015. The consultation notes identified the resident's increasing verbal and physical aggression, and difficult behaviour management at that time. The resident was noted to have a history of a specified medical condition. This information had not been transferred to resident #015's care plan.

During interviews with PSW #179 and PSW #180 on a specific date in July 2016, they both stated to the Inspector that there was no reference to responsive

behaviours in the resident #015's care plan dated from May 2016. They stated that this resident's care plan should have identified their known triggers and staff's response to this resident's responsive behaviours.

On a specific date in July 2016, PSW #181 informed the Inspector that they were aware of the resident's responsive behaviours since admission. They stated the resident known to demonstrate physical and verbal responsive behaviours, unprovoked. They stated this information would be found in the resident's care plan and kardex, however on review with the Inspector, there was no responsive behaviour information regarding these behaviours found.

The Inspector interviewed PSW #193 on a specific date in July 2016. Although PSW #193 stated they were familiar with resident #015, they were not aware of any responsive behaviours that included previous physical or verbal altercations with co-residents. They stated information related to any behaviours would be in the resident's care plan, and as they were aware there was no information related to behaviours.

During an interview with Manager #126, they stated to the Inspector that the resident's known history of responsive behaviours that included physical aggression toward other residents should have been included in their plan of care to protect resident #016 from abuse.

Non-compliance was also identified during this inspection related to WN #2, LTCHA, 2007, O. Reg. 79/10, s. 53 (4) where the home failed to ensure that for resident #015's demonstrated responsive behaviours, strategies were developed and implemented to respond to those behaviours. [s.19.(1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident that demonstrated responsive behaviours, strategies were developed and implemented to respond to those behaviours where possible.

Inspector #621 reviewed a CI report that was submitted to the Director for an incident of resident to resident physical abuse that occurred on July 2016, between resident #020 and #019, which resulted in injury to resident #019.

During a review of documentation for resident #020 between January and July 2016, Inspector #621 identified 25 incidents of responsive behaviours, four of which were incidents of responsive behaviours between resident #020 and #019 where resident #020 was the aggressor. See WN #1, finding 1 for further information.

During interviews with RN #124 and PSW #148 on a specific day in July 2016, they indicated that resident #019 was a trigger for resident #020, and that incidents between these two residents had occurred since resident #019 had a room

reassignment in June 2016.

When the Inspector asked PSW #148 what forms of documentation were kept to identify that staff were monitoring resident #020 for responsive behaviours, it was reported that they were not aware of any formal documentation except for when an incident occurred, it would be added to the progress notes.

Inspector #621 reviewed resident #020's most current care plan from May 2016, which documented responsive behaviours under the Behaviour Problems focus, however there had been no care plan updates after May 2016, in spite of two critical incidents reported to the Director for altercations between resident #020 and #019 causing injury to resident #019. Additionally, there were no strategies care planned for to identify resident #019 as a known trigger for resident #020 and how to manage this.

A review of the home's policy titled "Responsive Behaviours Program – LTC 3-50", last revised March 2016, referred to an accompanying document titled "Long-Term Care Responsive Behaviours Toolkit", last revised May 2016, which identified that a key aspect of resident care included prevention or minimization of situations in which a resident exhibited responsive behaviours. As part of the prevention strategies the toolkit identified that assessment included utilization of screening tools such as the Dementia Observation System (DOS), and documentation of observations was to be found in the resident chart and progress notes.

On a specified date in July 2016, Inspector #621 reviewed resident #020's documentation and identified DOS charting had occurred for one week in July 2016, but that the DOS record was incomplete. Additionally, no DOS records were found between January and June 2016, when 25 incidents of responsive behaviours were documented by staff.

During an interview in July 2016, RN #124 identified that DOS charting could be initiated by staff at any time, and that a specific request for DOS charting was made by Manager #123 on a specific date in July 2016 to begin that day and for a one week period.

In an interview, RN #124 reported that a DOS was initiated for one week in July 2016, as requested by Manager #123, but identified to the Inspector that the DOS record was incomplete. Additionally, RN #124 identified that no DOS charting had been done to monitor resident #020's responsive behaviours between January and

July 2016, when 25 incidents of responsive behaviors between resident #020 and co-residents were documented to have occurred.

During an interview on a specific date in July 2016, Manager #123 identified that it was their expectation that as part of responsive behaviour monitoring of residents, strategies including DOS charting would be completed on those residents, including resident #020 with known responsive behaviours. Additionally, Manager #123 expected that strategies to mitigate this resident's physically responsive behaviours would be documented in this resident's care plan and kept current. On review of resident #020's chart, Manager #123 confirmed that DOS charting was not completed in spite of numerous incidents reported in the documentation, and DOS charting that was directed by them to be completed between specific dates in July 2016, was found incomplete. [s.53.(4) (b)]

2. Inspector #616 reviewed four CI reports submitted by the home that involved physical altercations between resident #015 and co-residents #016, #018, #029, and #028 in June and July 2016.

The Inspector reviewed the progress notes in resident #015's electronic health record related to all documented incidents of responsive behaviours from the time of their admission to a particular date in June 2016, when a physical altercation between resident #015 resulted in abuse of co-resident #016. A total of six incident notes were identified during this time which reported physical altercations from resident #015 towards unidentified co-residents.

The Inspector reviewed resident #015's admission care plan from February 2016, and the most current care plan dated from May 2016, related to responsive behaviours. Neither care plan included strategies to be implemented in response to these behaviours. On further review, a 24 hour care plan from February 2016, identified that the resident was known to have demonstrated verbal and physical aggression.

The Inspector found additional information within the resident's documentation related to behaviours. Two consultation notes from May 2015 identified resident #015's increasing verbal and physical aggression and difficult behaviour management. The resident was noted to have a specified medical diagnosis. The Inspector noted this information had not been used to develop any strategies to respond to this resident's responsive behaviours.

During interviews with PSW #179 and PSW #180 in July 2016, they both stated to the Inspector that there was no reference to responsive behaviours in the resident's care plan from May 2016. On a specific date in July 2016, PSW #181 informed the Inspector that they were aware of the resident's responsive behaviours from their admission to the home area which included unprovoked physical and verbal aggression. They stated this information would be found in the resident's care plan and kardex. However on review the care plan and kardex, the PSW stated there was no responsive behaviour information found.

The Inspector also interviewed PSW #193 on a specific date in July 2016. Although PSW #193 stated they were familiar with resident #015, they were not aware of any responsive behaviours that included previous physical or verbal altercations with co-residents. They stated information related to any behaviours would be in the resident's care plan, and as they were aware there was no information in this resident's care plan related to behaviours.

The Inspector reviewed the home's policy titled "Responsive Behaviour Program", last revised March 2016, which referred to the home's Responsive Behaviour Toolkit, last revised May 2016. This toolkit stated that interventions were developed in the resident's plan of care to minimize responsive behaviour triggers, provide effective staff response for specific residents, to minimize the risk of altercations, and prevent the escalation of potentially harmful or abusive situations.

During an interview with Manager #126 they stated to the Inspector that the resident's known history of responsive behaviours that included physical aggression toward other residents, with strategies for staff to address the responsive behaviours should have been included in their plan of care and was not. [s.53.(4) (b)]

3. The licensee has failed to ensure that for each resident that demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Inspector #621 reviewed a CI report that was submitted to the Director for an incident of resident to resident sexual abuse which occurred in April 2016. In addition to this CI, Inspector #621 reviewed this resident's documentation over a six month period between January and July 2016 and identified six additional incidents of sexual responsive behaviours reported to have occurred by resident

#030 towards co-residents. See WN #1, finding 2 for further details specific to incidents identified in resident #030's documentation.

During an interview with RN #124, they indicated to Inspector #621 that staff utilized a number of strategies to mitigate resident #030's sexual responsive behaviours.

When the Inspector asked where staff would find information on strategies to use to mitigate sexual responsive behaviours, RN #124 indicated that the resident's care plan found on their chart and the electronic health record would provide this information.

Inspector #621 reviewed resident #030's written plan of care, including the resident's care plan, last revised in July 2016, and found no strategies identified by RN #124.

RN #124 reviewed the most current care plan from July 2016, and reported that both the hard copy and electronic version of resident #030's care plan did not include any documented strategies for manage this resident's sexual responsive behaviours.

A review of the home's policy titled "Responsive Behaviours Program – LTC 3-50", last revised March 2016, referred to an accompanying document titled "Long-Term Care Responsive Behaviours Toolkit", last revised May 2016, which identified that a key aspect of resident care included prevention or minimization of situations in which a resident exhibited responsive behaviours. As part of the prevention strategies the toolkit identified that assessment included utilization of screening tools such as the Dementia Observation System (DOS), and documentation of observations was to be found in the resident chart and progress notes.

On review of resident #030's chart, RN #124 reported that no DOS charting had been done to monitor resident #030's sexual responsive behaviours between January and July 2016 in spite of incidents documented by staff during this time.

During an interview on a specific date in July 2016, Manager #123 identified that it was their expectation that as part of responsive behaviour monitoring of residents, strategies including DOS charting would be completed on those residents, including resident #030 with known responsive behaviours. Additionally, Manager #123 expected that strategies to mitigate this resident's sexual responsive

behaviours would be documented in this resident's care plan. On review of resident #030's documentation, Manager #123 confirmed that DOS charting was not completed and a care plan for sexual responsive behaviours had not been completed. [s.53.(4) (b)]

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. 6. Plan of care
Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

(A2)
1. The licensee has failed to ensure that there was a written plan of care that set out the planned care for the resident.

Inspector #621 reviewed a CI report that was submitted to the Director in April 2016, which identified an incident of resident to resident sexual abuse. See WN #1, finding 2 for details pertaining to the review of resident #030's records.

During an interview in July 2016, RN #124 reported to Inspector #621 that resident #030 had demonstrated sexual responsive behaviours since their admission. RN #124 indicated that staff utilized a number of strategies to mitigate resident #030's sexual response behaviours. When Inspector #621 asked where staff would find information on strategies to use to mitigate sexual responsive behaviours, RN #124 indicated that the resident's care plan found on the chart and in the electronic health record would provide this information.

Inspector #621 reviewed resident #030's care plan, last revised in July 2016, and found no interventions including strategies identified by RN #124 to address this resident's sexual responsive behaviours.

RN #124 reviewed resident #030's plan of care and reported to the Inspector that both the hard copy and electronic version of resident #030's care plan did not include any documentation for this resident's sexual responsive behaviours, including goals or management strategies.

During an interview with Manager #123, they reported that it was their expectation that documentation of resident #030's sexual responsive behaviours as well as the goals and interventions would be found in the resident's care plan found in hard copy on the chart and on the electronic health record. Manager #123 identified that a care plan for sexual responsive behaviours had not been completed, and should have been. [s. 6.(1)(a)]

2. On a specific date in July 2016, Inspector #621 observed resident #003's bed to have bed rails in "guard" position. On another day in July 2016, Inspector #617 observed resident #003 lying in bed and bed rails were in "guard" position. Inspector #617 observed resident #003 grab the bed rail closest to the door and use it to sit up from a lying position at the side of the bed.

On another day in July 2016, Inspector #617 interviewed resident #003 who was lying in their bed at the time. Resident #003 reported to the Inspector that they used bed rails to get up from the bed and to turn over at night.

On the same day in July 2016, Inspector #617 interviewed PSW #146 who

confirmed that resident #003 used bed rails for bed mobility. At the time of the interview PSW #146 reviewed resident #003's kardex and care plan at the nursing station and confirmed to the Inspector that they did not indicate the use of bed rails.

During an interview with the Acting DOC, they confirmed to the Inspector that the use of bed rails for residents was expected to be in their care plans. [s. 6.(1)(a)]

3. On a specific date in July 2016, Inspector observed resident #004 lying in their bed with bed rails in "guard" position.

Inspector #617 reviewed #004's care plan and kardex, both revised in July 2016, which did not indicated the use of bed rails.

On a specific date in July 2016, Inspector #617 interviewed PSW #145, who confirmed that resident #004 used bed rails in "guard" position for safety. At the time of the interview PSW #145 reviewed resident #004's kardex and care plan and confirmed to the Inspector that they did not indicate the use of bed rails.

During an interview with the Acting DOC, they confirmed to the Inspector that the use of bed rails for residents was expected to be in their care plans. [s. 6.(1)(a)]

4. In July 2016, Inspector #616 observed resident #010 sitting in their chair with a safety device engaged. On another date in July 2016, Inspector #617 observed resident #010 sitting in their chair with a safety device engaged across their waist.

A review of resident #010's plan of care by the Inspector, which included review of the kardex and care plan, last revised in July 2016, did not identify the use of a safety device on their chair.

On a specific date in July 2016, Inspector #617 interviewed PSW #132 who confirmed that resident #010's had a safety device on their chair. On the same date in July 2016, Inspector #617 interviewed PSW #144 who reported that they applied the safety device after transferring resident #010 into their chair.

PSW #144 reviewed resident #010's kardex and care plan dated from July 2016, and reported that there was no information to identify that a safety device was used.

On a day in July 2016, Inspector #617 interviewed RPN #112 who confirmed that they had updated resident #010's care plan on a specific date in July 2016, and the care plan did not include the use of a safety device. RPN #112 explained to the Inspector that when resident #010 was admitted in early 2016, they updated the care plan during their shift and did not want to go into resident #010's room and wake them in order to determine the type of safety device used. [s. 6.(1)(a)]

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

The home had submitted four CI reports to the Director for allegations of resident to resident physical abuse that involved resident #015 during summer of 2016.

Inspector #616 reviewed and compared resident #015's current electronic care plan dated from June 2016, to the printed care plan from their chart dated from May 2016. Discrepancies were identified between the two care plans related to responsive behaviours. The printed care plan did not include a responsive behaviour focus whereas the electronic care plan included this focus with strategies and interventions.

In an interview with RPN #182 on a specific day in July 2016, they stated that the written care plan in the resident's chart was the most current and they stated they expected to find responsive behaviours identified there. RPN #182 and the Inspector reviewed the resident's chart which contained the printed care plan dated from May 2016. The RPN stated in this care plan, there was no reference to responsive behaviours or how to manage the behaviours as identified in the electronic care plan.

On a specific day in July 2016, the Inspector interviewed PSWs #180 and #183. They stated they expected resident #015's responsive behaviours to be on the resident's care plan. PSW #180 retrieved a care plan from the resident's chart dated from April 2016. This care plan was in addition to the printed care plan identified previously by RPN #182, and the Inspector. Both PSWs stated this version did not include any behaviour problems. PSW #183 stated that the care plan should have been updated to reflect the increase in responsive behaviours demonstrated by this resident and interventions for staff to manage their responsive behaviours.

On a specific day in July 2016, PSWs #184 and #179 stated they accessed paper copies of the resident's care plans from the resident's chart. They each stated they were unfamiliar with how to access the electronic care plan (e-plan), and had not received direction or training to access the e-plan. During an interview with RPN #185 on this day, they stated to the Inspector that the registered staff were responsible to print the most current and up to date care plan for the PSW staff to reference on paper.

During Inspector #616's interview with Clinical Manager #126 on a specific date in July 2016, they verified that the registered staff updated the resident care plans electronically and printed the most current copy for the PSW staff. They added that the PSW staff were not expected to review the care plan electronically and had not received training on how to access the care plan electronically. Furthermore, they stated that both the electronic care plan and the paper care plan should have contained the same information and should have been accessible to all staff providing care to resident #015. [s. 6.(1)(c)]

6. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Inspector #621 reviewed a complaint received by the Director in May 2016, which alleged resident #026 was not being monitored and released from their safety device as per legislative requirements.

A review of resident #026's care plan, last revised in May 2016, identified under the "Restraints" focus that staff were to check this resident's safety device hourly and release the safety device with repositioning of the resident every two hours while in their chair.

During an interview in July 2016, PSW #122 reported to Inspector #621 that documentation for restraint monitoring, restraint release/reapplication, and repositioning of a resident with restraints was entered into Point of Care (POC) under the flow sheet tracker for restraints. They identified that for residents with restraints, PSW staff were required to complete a restraint check hourly and every two hours release the restraint and reposition the resident.

Inspector #621 reviewed a copy of the restraints flow sheet report for resident #026 during May 2016. Evidence of hourly monitoring and completion of restraint release and repositioning every two hours could not be determined as the restraint

flow sheet report only recorded the last time a PSW completed the task during their shift. On follow up with RAI/MDS Coordinator #173, it was determined that the software did not generate reports that would show each entry made by PSW staff over a 24 hour period.

A review of the home's policy and accompanying document titled "Long-Term Care Least Restraint Program Toolkit", last revised June 2016, identified that PSW staff were to document in Medecare as per PASD/restraint monitoring protocols (Appendix F) which was the electronic flow sheet for restraints within POC.

During an interview in July 2016, Manager #123 identified it was their expectation that restraints were monitored with subsequent release and repositioning as per legislative requirements, and that documentation which evidenced that care was provided would be found from a POC task report specific to restraint monitoring, release and repositioning.

Manager #123 reviewed the May 2016 restraint flow sheet report generated from the electronic health records for resident #026 and reported that they were unable to determine from the report if hourly checks of resident #026's safety device were completed or if the safety device was released and the resident repositioned every two hours. They identified that the home did not utilize another tracking method, and consequently did not have documentation to evidence that care had been provided as documented in the plan of care for this resident. [s. 6.(9)1]

7. A complaint was received by the Director regarding concerns about inadequate oral care being provided to resident #026.

During a review of resident #026's most current care plan dated from May 2016, it was identified by Inspector #621 that this resident was to be provided staff assistance for specific oral care every morning and evening.

Inspector #621 completed a review of resident #026's dental care records from May 2016, and found no documentation that oral care was completed for two specific days in May 2016, and in 15 out of 31 days during May 2016, mouth care was found to be completed only once daily. Additionally, more specific oral care that was to be given was documented to have only been provided twice during May 2016.

During an interview in July 2016, PSW #122 and RN #124 reported that PSW staff

was to assist resident #026 with mouth care every morning and evening, which included specific oral care and that documentation of this care was to be entered by PSW staff into the Point of Care (POC) electronic records daily for each resident.

During an interview in July 2016, Manager #123 identified to Inspector #621 that it was their expectation that mouth care be provided to residents at minimum twice daily, once in the morning and once in the evening and PSW staff document this care in the task report section of the POC electronic record for each resident. Manager #123 reviewed resident #026's dental care task report from POC for May 2016, and reported to Inspector #621 that documentation regarding provision of daily oral care as per this resident's plan of care had not been completed by the PSW staff as required. [s. 6.(9)1]

8. A complaint was received by the MOHLTC for two days in June 2016, related to resident #025's missed baths over a specific period of time in June 2016.

In a telephone interview with the complainant, Inspector #616 was informed that resident #025 had not received their scheduled baths between two specific dates in June 2016.

During the Inspector's interview with resident #025, they stated their baths were scheduled for two particular days of the week.

A review of the care plan related to bathing identified the resident's preference for a specific type of bath during a specific time of the day. The bath list identified that this resident was scheduled for baths on two specific days of the week.

The Inspector reviewed the resident's bath task report from Point of Care (POC) from two specific dates between the spring and summer of 2016. The documentation indicated that the resident received 55 per cent of scheduled baths within this time period as documented in their progress notes. The Inspector found no documentation for 33 per cent of the scheduled baths during this time period.

In addition to resident #025, the Inspector reviewed the bath records, care plans, and corresponding documentation for residents #006 and #007.

Resident #006's current plan of care identified this resident's scheduled bath days were on two specific days of the week during a specific time of day.

Inspector #616 reviewed resident #006's POC bath task report between two specific days between the spring to the summer of 2016. The documentation was incomplete on 55 per cent of the scheduled bath days. There were no progress notes found by the Inspector that documented the missed baths for 55 per cent of the scheduled bath days.

A review of resident #007's current plan of care identified this resident's preference for baths, and that this was scheduled on the bath list for a specific frequency of baths on specific days as also indicated on their 24 hour admission care plan.

The Inspector reviewed resident #007's POC bath task report from two specific dates during the spring and summer of 2016, and found the documentation incomplete on 50 per cent of the baths.

The Inspector also reviewed progress notes and found none related to the scheduled baths 50 per cent of the scheduled baths during that specific period of time in 2016.

PSW #187 stated to the Inspector that blank documentation in the POC bath report indicated that the PSWs ran out of time to document that they provided a bath.

During an interview with the Inspector on a specific date in July 2016, RPN #186 and the Client Care Coordinator #143, they each stated that the PSWs documented the provision of baths on POC. However, RPN #187 stated that if a resident had not received their scheduled bath/shower due to the resident's refusal, the PSW documented "refused" on the POC, in addition to documentation on a progress note. Client Care Coordinator #143 had stated to the Inspector that if there was any other reason the resident missed their bath, this information would have been documented on report to the oncoming shift to make up the bath if possible. They also stated there was a form used by the home for missed baths called the "bath report" where staff documented which resident had not received their bath.

During an interview with Manager #126, they stated to the Inspector that the PSWs were expected to document all care provided in POC, including baths. They stated that the documentation for baths should have been completed but was not. [s. 6. (9) 1.] (616)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that: a) there is a written plan of care that sets out the planned care for the resident; b) the staff and others who provided direct care are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it; and c) the provision of care as set out in the plan of care is documented, to be implemented voluntarily.

WN #4: 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 where the Long Term Care Homes Act or Regulation 79/10 required the licensee of the long term care home to have, institute or otherwise put in place a policy and ensured that the policy was complied with.

On review of resident #010's electronic weight record, Inspector #621 identified missing monthly weights for April, May, and June 2016.

A review of the home's policy titled "Unintentional Weight Loss or Gain – LTC 5-10", last revised January 2013, identified that residents were weighed on the same scale, at the same time of day each month, usually on bath day; and weights were recorded in the electronic health record.

During an interview in July 2016, RPN #112 identified that resident weights were to be taken within the first week of each month and that a PSW on night shift would then enter the weights into the electronic health record. RPN #112 reviewed the electronic health record for resident #010 and reported to Inspector #621 that weights for April, May and June 2016 had not been entered and should have been.

During an interview on a specific day in July 2016, the Acting DOC reported to Inspector #621 that it was their expectation that PSW staff would take weights of residents monthly and that weight measures would be documented the same day into the electronic health record by PSW staff on the night shift. On review of the electronic weight record for resident #010, the Acting DOC reported that monthly weights were not recorded for April, May or June 2016 as per homes policy, and should have been. [s. 8. (1) (a),s. 8. (1) (b)]

2. During a review of resident #026's progress notes, Inspector #621 identified that a fall without injury had occurred in May 2016. It was reported that this resident was found by PSW staff sitting on the floor next to their wheelchair in a common room.

A review of resident #026's paper chart and electronic health record by Inspector #621 found no evidence that a Head Injury Routine (HIR) had been completed for the fall of resident #026 in May 2016.

A review of the home's policy and accompanying documented titled "Long-Term Care Falls Prevention and Management Tookit", last revised May 2012, identified that Registered Nursing staff would initiate a HIR for all unwitnessed falls and witnessed falls that resulted in a possible head injury. This would include monitoring every hour for the first four hours and then every four hours for 24 hours post fall for signs of neurological changes.

During an interview on a specific day in July 2016, Manager #123 reported to Inspector #621 that it was their expectation that a HIR was initiated after every

unwitnessed fall of a resident within the home. On review of resident #026's documentation, Manager #123 identified that for the May 2016 unwitnessed fall, no HIR had been completed, and should have been. [s. 8. (1) (a),s. 8. (1) (b)]

3. Inspector #616 reviewed resident #007's Resident Assessment Instrument Minimum Data Set (RAI MDS) assessment, dated from May 2015, which identified that they had a altered skin integrity.

The Inspector reviewed resident #007's Wound Assessment Tool (WAT) from April 2016, which identified altered skin integrity. A physician order dated from a specific date in May 2016 was transcribed to the WAT for the wound dressing to be changed every two days and as needed. A further review of the WAT by Inspector #616 over a period of seven days in May 2016 identified that documentation of the ordered wound dressing change was incomplete.

During interviews with PSW #188 and RN #189, they stated to Inspector #616 that the resident was known to have a pressure ulcer. RN #189 stated to the Inspector that staff documented the administration of the resident's wound treatments and orders on the home's Wound Assessment Tool, as part of the plan of care.

The Inspector reviewed the home's policy titled "Skin and Wound Care Program - LTC 3-80", last revised September 2012, which referred to the program outlined in the Skin and Wound Care Program Toolkit. The toolkit instructed registered staff to implement interventions for the prevention of further skin breakdown and to complete the Wound Assessment Tool (WAT) after each dressing change. Further review of the home's WAT included documentation of wound size, exudate, dressing description, interventions, stage, undermining, odour, and pain scale.

During the Inspector's interview with RN #189, they stated that as per policy, all dressings for resident #007's wound should have been completed and documented on the Wound Assessment Tool but was not for seven days in May 2016. [s. 8. (1) (a),s. 8. (1) (b)]

4. Resident #004 was identified to have had a staged pressure ulcer. The Inspector noted that altered skin intergrity was first identified on this resident's Wound Assessment Tool (WAT) in February 2016, without the wound's dimensions documented. On a specific date in March 2016, the area was restaged, and in April 2016, the altered skin integrity had deteriorated further.

Inspector #616 reviewed the Skin and Wound Care Program policy, #LTC 3-80, last revised September 2012, which referenced the home's Skin and Wound Care Program Toolkit dated September 2012. Within the toolkit, it stated that after a dressing change, the registered staff were to complete the Wound Assessment Tool. Further review of the policy identified that weekly documentation was to include: "size (circumference and depth), discharge, appearance, and progression of the wound, pain, nutrition, and equipment being used."

During interviews with RN #189 and RN #138 in July 2016, they stated that the RPN staff completed the Wound Assessment Tool with wound dressing changes as per the physician's order, and the weekly wound assessments were completed and documented in the resident's progress notes.

The Inspector reviewed resident #004's documentation over a 144 day period between February and July 2016, and found no documentation related to required weekly wound assessments.

On a specific date in July 2016, Manager #126 stated to the Inspector that registered staff completed dressing changes as per a physician's order and documented on the WAT. During this interview, they also stated that the registered staff completed and should have documented a weekly wound assessment in the progress notes of the resident's electronic health record. [s. 8. (1)]

5. Resident #006 was identified on their WAT from February 2016, to have had altered skin integrity. The wound documentation from May 2016, compared to February and March 2016, noted progressive altered skin integrity deterioration.

The Inspector reviewed resident #006's progress notes related to weekly wound assessments from February 2016, when altered skin integrity was identified and documented, through to June 2016, and found no documentation related to the required weekly wound assessments. [s. 8. (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 where the Long Term Care Homes Act or Regulation 79/10 requires the licensee of the long term care home to have, institute or otherwise put in place a policy for skin and wound management, weight monitoring and recording, and falls prevention and management, and the licensee ensures that the policy is complied with, to be implemented voluntarily.

WN #5: 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 their bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

On a specific day in July 2016, Inspector #616 observed resident #010's bed with bed rails in "guard" position. On another day in July 2016, Inspector #617 observed resident #010 sitting in their wheelchair beside their bed and bed rails in "guard" position.

On the same day in July 2016, Inspector #617 interviewed resident #010 who

reported that they used bed rails to help them to turn over in bed during the night.

Again, on the same day in July 2016, Inspector #617 interviewed PSW #144 who confirmed that they engaged bed rails in "guard" position on resident #010's bed because this resident would use them for mobility.

A review of resident #010's electronic health record indicated that they used bed rails. Additionally, the Resident Assessment Instrument/Minimal Data Set (RAI/MDS), last revised in February 2016, indicated that this resident used bed rails daily. Finally, resident #010's care plan dated from July 2016, instructed the PSW staff to have bed rails in "guard" position when the resident was in bed and to encourage them to use the bed rails as staff assisted them with mobility. However, when Inspector #617 reviewed resident #010's plan of care, they could not find a completed assessment for resident #010's use of bed rails. [s. 15.(1) (a)]

2. On a specific day in July 2016, Inspector #617 observed resident #004 lying in their bed with bed rails in "guard" position at the top of the bed.

On another day in July 2016, the Inspector interviewed PSW #145 who confirmed that resident #004 used bed rails for safety.

A review of resident #004's Resident Assessment Instrument/Minimal Data Set (RAI/MDS), last revised in January 2016, indicated that the resident used bed rails daily. Resident #004 was admitted in early 2016, and their 24 hour admission care plan at that time indicated that they used bed rails. Inspector #617 however, could not find an assessment for resident #004's use of bed rails. [s. 15.(1) (a)]

3. On a specific day in July 2016, Inspector #621 observed resident #003's bed to have bed rails in the "guard" position.

On another day in July 2016, Inspector #617 observed resident #003 lying in bed and bed rails were in "guard" position at the top of the bed with the call bell attached for use. The Inspector observed resident #003 grab the bed rail closest to the door and use it to sit up from a lying position at the side of the bed.

On the same day in July 2016, the Inspector interviewed resident #003 who was lying in their bed at the time. Resident #003 reported to the Inspector that they used bed rails for mobility when in bed. Inspector #617 also interviewed PSW #146 who confirmed that resident #003 used bed rails in "guard" position for mobility

when in bed.

A review of resident #003's Resident Assessment Instrument/Minimal Data Set (RAI/MDS), last revised in January 2016, indicated that this resident used bed rails daily for bed mobility and transferring. Inspector #617 however, could not find an assessment for resident #003's use of bed rails.

A review of the home's policy titled "Bed Safety-Prevention of Entrapment-LTC 5-80", last revised June 2016, indicated that bed rail use was to be assessed regularly using the "Bed Rail Safety Analysis".

On a specific day in July 2016, Inspector #617 interviewed RN #149, who confirmed that residents #004, #003 and #010 did not have an assessment completed using the "Bed Rail Safety Analysis" and identified to the Inspector that they were not aware of the home's policy regarding bed rail assessment.

On the same day in July 2016, the Inspector interviewed the VP Seniors' Health/Administrator, who confirmed that the home's policy regarding bed rail assessment had not yet been implemented in the home. [s. 15.(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 where bed rails are used, resident's #004, #003, and #010 are assessed and their bed system evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to these residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On a specific day in July 2016, Inspector #616 observed on a specific unit, damage to the drywall above the baseboard along the main corridor wall, where the paint and part of the wall were missing along the wall across an area measuring five centimeters in width and 60 centimeters in length.

During five days in July 2016, Inspector #617 observed a rectangular gouge measuring five centimeters in width and 60 centimeters in length above the baseboard on the wall across from the elevators on the first floor.

On a specific day in July 2016, Inspector #617 observed the following damaged drywall where the paint and part of the wall were missing which measured five centimeters in width and 60 centimeters in length:
- along the base of the red wall behind the nursing station on a specific unit;
- along the base of the hallway walls upon entry from the dining room towards specific resident rooms; and
- along the base of all three sides of the red wall behind the nursing desk on a specific unit.

During an interview with Maintenance Supervisor #125, it was reported to the Inspector that the maintenance department was aware of the wall disrepair from department audits and/or maintenance requests submitted by the nursing department, and confirmed the wall damage found in all areas that were identified by Inspector #616 and #617 in July 2016.

Maintenance Supervisor #125 explained that the damage to the walls was caused by equipment and wheelchairs and repairs to the walls was scheduled to be done by priority. [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 home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A CI report was submitted to the Director for an incident of resident to resident sexual abuse occurring in April 2016.

Inspector #621 reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect of Residents – LTC 5-50", last revised February 2016, which identified that residents living in the home had the right to be free from mental and physical abuse.

During an interview in July 2016, Manager #126 reported to Inspector #621 that the results of the investigation determined the actions of resident #032 towards resident #033 constituted sexual abuse. Consequently, the home was not in compliance with their written policy on zero tolerance of abuse and neglect of residents. [s. 20. (1)]

2. A CI was reported from the home to the Director regarding resident to resident abuse involving residents #020 and #019. The CI occurred on a specific date in

July 2016, and was submitted to the Director by Manager #123 three days later.

A review of the home's policy titled, "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications About Incidents of Abuse or Neglect - LTC 5 -51", last revised February 2016, indicated that the Director/designate and/or VP Seniors' Health must be notified immediately and that they would notify the Ministry by phone. The policy also identified that notification was followed by immediate initiation of a report using the on line Mandatory Critical Incident System (MICS) form under the Mandatory Report Section.

On a specific day in July 2016, Inspector #617 interviewed Manager #123 who confirmed that they were notified by email from RPN #167 an earlier date in July 2016, regarding a resident to resident altercation that occurred and resulted in a resident injury. During the interview, Manager #123 clarified that they were not in the building after a specific time on the day following the incident, and did not read their email until three days later. Manager #123 confirmed to the Inspector that when they read their email they reported the CI to the Director immediately.

On another day in July 2016, Inspector #617 interviewed the VP Seniors' Health/Administrator, who confirmed that during business hours when the manager was available in the building, registered staff were expected to email the manager immediately to inform them of critical incidents that occurred with residents which were defined as a mandatory report to the Director. The VP Seniors' Health/Administrator reported that it was their expectation that the managers would check their emails or have a designate in place to review their emails and respond accordingly. [s. 20. (1)]

3. Inspector #621 reviewed a CI report that was submitted to the Director in April 2016, which identified an incident of resident to resident sexual abuse. See WN #1, finding 2 for further details specific to incidents identified in resident #030's documentation.

The Inspector reviewed the home’s policy titled “Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications about Incidents of Abuse and Neglect – LTC 5-51”, last revised February 2016, which identified that staff members who witnessed or suspected alleged incidents of resident abuse or neglect were to immediately report to the Director/designate or VP Seniors’ Health. The policy also identified that the Director/designate and/or VP Seniors’ Health must be notified immediately and that they would notify the Ministry of Health and

Long-Term Care (MOHLTC) by phone and begin the investigation process.

During an interview on a specific day in July 2016, Manager #123 identified to Inspector #621 that it was their expectation that any suspected incidents of abuse be reported by staff as per the home's policy, which included forwarding an email notification of the incident to Manager #123, who would to then report it to the MOHLTC and initiate an investigation to determine whether the incidents constituted abuse. Manager #123 reviewed the documentation for resident #030 between specific dates in January and July 2016, and confirmed to the Inspector that the identified incidents constituted suspected sexual abuse and that the incidents were not reported by staff as per home's policy. [s. 20. (1)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home had a compliance order from report #2016_246196_0006 (A1) for s.24 with a compliance date of June 30, 2016. The incidents identified within this report occurred prior to the compliance order due date.

A CI was reported from the home to the Director regarding resident to resident abuse involving residents #015 and #016, which resulted in injury. The CI occurred on a specific day in June 2016, however it was not reported to the Director until the next day.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications about Incidents of Abuse or Neglect - LTC 5-51", last revised February 2016, indicated that the Director/designate and/or VP Seniors' Health was to be notified immediately and they would then notify the Ministry by phone and immediately initiate a report using the on line Mandatory

Critical Incident System (MICS).

On a specific date in July 2016, Inspector #617 interviewed Manager #126, who confirmed that they received notification of the incident by email on a specific date in June 2016, from RN #165 and confirmed that they were aware of the incident at the time it occurred. During the interview Manager #126 reported that they were expected to review emails sent to them after hours by the registered staff and report any critical incidents that occurred in the home which required immediate reporting to the Director. Manager #126 confirmed to the Inspector that they should have reported the critical incident immediately, but did not.

On another day in July 2016, Inspector #617 interviewed the VP Seniors' Health/Administrator, who confirmed that when the manager was available in the building during business hours, registered staff were expected to email the manager immediately to inform them of the critical incident, and which were defined as a mandatory report to the Director. The VP Seniors' Health/Administrator reported that it was their expectation that the manager would check their emails or have a designate in place to review their emails and respond accordingly. [s. 24.]

2. A CI was reported by the home to the Director regarding an incident in which a specific number of residents were not administered their medications by assigned RN #150. The CI occurred on a specific day in June 2016, however, the home did not report the incident to the Director until five days later.

A review of the CI report indicated that Manager #156 reported the CI to the Director. A review of the home’s internal investigation indicated Manager #156 was aware of the CI when they arrived on the unit that day and found RN #150's medication cart in disarray and was concerned for the residents. It was documented that on that same day and shift, Manager #156 sent RN #150 home with pay pending further investigation.

On a specific day in July 2016, Inspector #617 interviewed the Acting DOC who confirmed that RN #150's actions were considered resident abandonment, and the medication errors were deemed incompetent treatment of residents, which placed them at risk of harm. The Acting DOC clarified to the Inspector that the CI should have been reported immediately to the Director using the after hour phone numbers when the incident occurred. [s. 24. (1)]

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items.

Inspectors #616 and #613 toured the home on a particular day in July 2016, which included inspection of multiple home areas.

Many unlabelled resident personal care items and products were observed by

Inspector #616 and #613 in the spa rooms on following home areas:

On a specific unit – Spa #2
-one pink Disney brush, used and not new on the counter
-one black hairbrush, used and not new on the counter
-one black comb, used and not new in the open cupboard

On a specific unit - Spa #2
-one brown paddle brush, used and not new on the counter

On a specific unit - Spa #2
-one pink paddle hair brush with black polka dots, used and not new on the counter

On a specific unit - Spa #1
-one blue paddle brush, used and not new on the counter
-one unwrapped bar of soap, used, by the sink

On a specific unit - Spa #2
-one pink comb with handle, used and not new in the side bin of a care cart

On a specific unit – Spa #2
-one black comb, used and not new on the counter
-one white hair brush, used and not new on the counter

On a specific unit – Spa #1
-two black combs, used and not new on the counter

On a specific unit - Spa #1
-two black combs, used and not new on the counter

On a specific unit - Spa #2
-one black comb, used and not new on the counter

On a specific unit - Spa #1
-six black combs, used and not new on the counter

On a specific unit - Spa #2
-one women's dove stick deodorant, used, on the counter

On a specific unit - Spa #1
-one used Axe stick antiperspirant, and one used Speed Stick deodorant were found on top of the nail clipper drawer

On a specific unit - Spa #1
-one pink comb with handle, used and not new, on top of a box of gloves on the counter
-one women's Degree stick antiperspirant, used

On a specific unit - Spa #2
-three black combs, two used and not new, on the nail clipper drawer

During interviews on a specific day in July 2016, RPN #141 and PSW #142 stated to Inspector #616 that labelling of personal care items and products was to be done by staff on the resident's admission and when the items were acquired.

During Inspector #616's telephone interview with the Client Care Coordinator #143 on a specific day in July 2016, they stated the home did not have a policy related to the labelling of resident's personal care items or products, however that PSW staff were expected to label the items and products for each resident. [s. 37. (1) (a)]

2. The licensee failed to ensure that resident #001, #008, and #009 had their personal wheelchairs cleaned as required.

On specific days in July 2016, Inspector #613 observed resident #001's, #008's and #009's mobility aids covered in dried food and dirt particles.

On July 8, 2016, Inspector #617 interviewed RPN #104, RPN #102, PSW #103, and PSW #100, who all reported that resident mobility aids were scheduled to be cleaned monthly, and the PSW staff working night shift were responsible to clean them and document completion of cleaning in the Pre-Start Up Binder located at the nursing station. PSW #103 reported to the Inspector that if a resident's mobility aid became soiled, they would do their best to clean it at that time.

A review of the home's policy titled "Cleaning/Decontamination of Equipment-IC 2-40", last revised September 2014, identified a cleaning schedule for mobility aids. The schedule indicated that resident 's mobility aids were to be cleaned monthly and when needed by the nursing staff.

On two days in July 2016, Inspector #617 observed resident #008 sitting in their mobility aid which was covered with food debris.

On a day in July 2016, the Inspector and PSW #100 approached resident #008 who was seated with their mobility aid in the dining room. PSW #100 confirmed to Inspector #617 that resident #008's mobility aid was covered with food debris and should have been cleaned.

On the same day in July 2016, Inspector #617 interviewed the Acting DOC, who confirmed that the expectation of the nursing staff was to clean mobility aids monthly or when soiled. [s. 37. (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 each resident of the home has his or her personal items a) labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, that the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Inspector #621 completed a record review which identified that resident #026 had a fall without injury on a specific day in May 2016. The PSW staff were said to have notified RPN #174 who completed the requisite post fall assessment.

A review of resident #026's paper chart and electronic health record by Inspector #621 found no evidence that a post fall assessment had been completed.

A review of the home's policy titled "Falls Prevention and Management Program Policy", last revised April 2014, identified that registered staff were responsible to complete the Post Fall Assessment following each resident fall.

During an interview on a specific day in July 2016, Manager #123 reported to Inspector #621 that they expected after every resident fall that a post fall assessment was completed by the RPN and/or RN on duty. Manager #123 reviewed resident #026's documentation and identified that for the fall that occurred in May 2016, no post fall assessment had been completed. [s. 49. (2)]

2. Inspector #613 completed a record review which identified resident #008 had three falls which occurred on specific dates in June and July 2016. The Inspector was unable to locate post falls assessments for two out of the three falls. A post fall assessment was completed in paper format for a fall that occurred in July 2016, but there were no post fall assessments for the falls that had occurred in June 2016.

The Inspector met with RN #137 who reviewed resident #008's electronic health record and paper chart and reported to the Inspector that they were unable to locate the post fall assessments the two falls from June 2016. RN #137 confirmed there were no post fall assessments completed for these two dates and they should have been completed after each fall. [s. 49. (2)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when the Family Council advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), within 10 days of receiving the advice, the licensee responded to the Family Council in writing.

On a specific day in July 2016, Inspector #617 observed on the Six South Bulletin Board located on the dining room wall, that a copy of the Family Council Minutes for the meeting held in May 2016, was posted. The following concerns were raised from the Council:
- family members shared that some staff were going for breaks during meal times, and that some meals were served cold;

- a family member brought up a concern that flat pins were being used to post the resident transfer cards in their rooms and that they could be a hazard if they fell out and were stepped on; and
- a family member commented on the smell of urine on the resident home areas and asked if the soiled linen carts and garbage lids could be closed when not providing care.

On a specific day in July 2016, Inspector #617 interviewed the Chair of Family Council, who confirmed that during the Family Council meeting in May 2016, concerns were raised by family members regarding meals being served cold too residents, the use of flat pins as a safety risk, and a suggestion to have all used linen hampers and garbage lids closed when not in use, to prevent the smell of urine in the hallways. The Chair of Family Council reported that they did not receive a response from the home in writing within ten days to the concerns or suggestions raised at the May 2016, meeting.

On a specific day in July 2016, Inspector #617 interviewed the Resident Engagement Coordinator (REC) #105, who explained that all concerns and suggestions raised at the Family Council Meetings were directed by email immediately following the Family Council meetings to the Managers of the departments in the home and identified that it was the Manager's responsibility to relay this information back to the REC #105 by email. The REC #105 indicated that they would then document the responses from the home to any concerns and/or suggestions within the body of the meeting minutes, and then ensure the minutes were posted within the home. During the interview, REC #105 confirmed to the Inspector that they did not provide a response to the Family Council’s concerns raised at the May 2016, meeting within ten days of the meeting and posted the response late. [s. 60. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), within 10 days of receiving the advice, the licensee responds to the Family Council in writing, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with a weight change of five per cent body weight, or more, over one month, a change of seven and one-half per cent body weight, or more over three months, and a change of ten per cent of body weight, or more, over six months, are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated.

During a review of resident #026's electronic weight record, Inspector #621 identified that for a one month period between May and June 2016, there had been a documented 5.24 per cent weight change. Additionally, over a six month period between January and June 2016, there had been a documented 18.8 per cent weight change.

In an interview, Registered Dietitian (RD) #106 confirmed that resident #026 had a 5.24 per cent weight change recorded between May and June 2016, as well as a 18.8 per cent weight change recorded over a six month period between January and June 2016. RD #106 identified that for these weight changes a referral had not been received from the RPN/RN in response to the significant weight changes, and should have.

During an interview on a specific day in July 2016, RN #124 reported to Inspector #621 that the PSW staff were responsible to take resident weights monthly, and a record of these weights were entered into the electronic health record by the registered nursing staff. RN #124 reported that any significant weight change that was identified would be referred by the RPN or RN to the RD by email, voice mail or in person. RN #124 reported that there was no record of a referral being sent for resident #026 to the RD for the significant weight change identified in June 2016.

During an interview with Manager #123 in July 2016, they reported to Inspector #621 that it was their expectation that weights were taken monthly, recorded by PSW's and/or the RPN/RN staff in the electronic health record on the same day. If there were significant weight changes, Manager #123 stated that they would expect a re-weigh to be done of the resident before entering the monthly weight into the electronic record. Additionally, Manager #123 indicated that for any significant weight change, including the significant weight changes recorded in June 2016, they would have expected that the RPN/RN completed a referral to the RD for further assessment. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated for a change of five per cent body weight, or more, over one month; a change of seven and one-half per cent body weight, or more, over three months; a change of ten per cent body weight, or more, over six months; and any other weight change that compromises the resident's health status, to be implemented voluntarily.

WN #13: 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 the planned menu items were offered and available at each meal and snack.

During the lunch meal service on a home area on a specific day in July 2016, Inspector #621 reviewed the menu and identified that residents were to be provided corned beef or egg salad sandwiches for the main and alternate entrees, and mixed berries as the alternate dessert choice.

During a review of the dining area service station, Inspector #621 observed that no pureed bread option was available for the corned beef or egg salad sandwiches, and the dessert choice of mixed berries was not available in a pureed texture.

A review of the diet census for this home area identified that three residents required a pureed textured diet.

Inspector #621 interviewed Dietary Aide's #114 and #115, who reported that although there were pureed corned beef and egg salad fillings for sandwiches, there was no pureed bread available to assemble the sandwich options for pureed diets, and there were no pureed berries for the mixed berry dessert option. Dietary Aides #114 and #115 identified that the cooks prepared the menu items for all diet textures, and that there should have been pureed bread and pureed mixed berries available for the lunch meal service.

During an interview with Nutrition Manager #117 on a specific day in July 2016, they indicated to the Inspector that it was their expectation that texture modified options would be available during meal service for each item listed on the planned menu. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1.The licensee has failed to ensure that drugs, including prescription topical creams were stored in an area or a medication cart that was secure and locked.

During the initial tour of the home on a specific day in July 2016, Inspector #616 observed the following:

- In a specific home area:
Prescription treatment creams were found in a clear plastic bin with a lid on top of the care cart, outside of a resident room. The care cart containing the prescription treatment creams was left unattended and unsupervised in the corridor. The prescription treatment creams and ointments were labelled with resident's names.

- In a specific home area:

Prescription treatment creams were found in a clear plastic bin with a lid labelled "Section A" on top of the care cart, beside a resident room. The care cart containing the prescription creams was left unattended and unsupervised in the corridor. The prescription treatment creams and ointments were labelled with resident's names.

On another day in July 2016, Inspector #616 observed the following on a home area:
- Prescription treatment creams were found in a clear plastic bin with a lid labelled "Section D" on top of the care cart, outside of a resident room. The care cart containing the prescription creams was left unattended and unsupervised in the corridor. The prescription treatment creams and ointments were labelled with resident's names.

On another day in July 2016, Inspector #613 observed the following in a specific home area:
-Prescription treatment creams were found in a clear plastic bin with a lid labelled with specific resident room numbers on top of the care cart, in between resident rooms. The care cart containing the prescription creams was left unattended and unsupervised in the corridor. The prescription treatment creams and ointments were labelled with resident's names.

On yet another day in July 2016, Inspector #613 observed the following in a specific home area:
-Prescription treatment creams were found in a clear plastic bin with the lid not on it. The care cart containing the prescription creams was left unattended and unsupervised in the corridor, between resident rooms. The prescription treatment creams and ointments were labelled with resident's names and exposed in the open storage bin.

During an interview on a specific date in July 2016, PSW's #128 and #130 confirmed that prescription treatment creams should not be left in the corridor unattended and that treatment creams were to be returned to the registered staff after application. PSW #130 reported that there was a lock on the bottom drawer of the care cart where they were supposed to keep the prescription topical creams when not in use.

Inspector #613 reviewed the home's policy titled, "Medication Storage in the Facility" last revised October 2012, which identified that medications were to be

stored safely, securely and properly, following manufacturers recommendations or those of the supplier, and in accordance with federal and provincial laws and regulations. The medication supply was to be accessible only to authorized personnel.

During an interview on a specific day in July 2016, Manager #126 confirmed to Inspector #616 that all resident prescribed treatment creams were to be locked up when not in use. The creams were not to be left on top of care carts unattended. [s. 129. (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 drugs, including prescription topical creams are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

On a specific day over a 30 minute period in July 2016, Inspector #616 recorded room temperatures on three floors.

On one floor, three residents were observed by Inspector #616 in the television (TV) lounge, they were covered with blankets in their mobility aids. The room temperature was measured at 21.3 degrees Celsius.

During an interview with resident #041, they were covered with a blanket and they complained to Inspector #616 of being too cold. PSW #190 stated to this Inspector that the maintenance staff maintained the room temperatures, and that the previous two days were "freezing".

On another floor, three residents were observed by Inspector #616 sleeping in the TV lounge, each covered with a blanket. The temperature was measured at 21.1 degrees Celsius.

PSW #191 stated to Inspector #616 that staff working on fourth floor were complaining that it was "freezing", and they covered the residents when they found the temperature too cold.

On another floor, residents #042 and #043 stated to this Inspector that they were cold in the TV lounge, and resident #043 complained of being cold in the tub room during their bath. During an interview with PSW #192, they stated to the Inspector that residents have complained to them that the dining room, TV lounge, and spa rooms were cold. The room temperature in the TV lounge on the fifth floor was measured at 21.8 degrees Celsius.

During an interview with Maintenance Supervisor #125 on a specific day in July 2016, they stated to Inspector #616 that they were aware of the required temperature maintenance of a minimum of 22 degrees Celsius, and that the home’s air system had not maintained this temperature. [s. 21.]

WN #16: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they reported to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

Inspector #613 reviewed a CI report that was submitted to the Director for an incident of resident to resident physical abuse resulting in injury, which occurred on a specific date in June 2016.

The Inspector reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications about Incidents of Abuse and Neglect", last revised February 2016, which identified that the Mandatory Critical Incident System (MCIS) included, but was not limited to, the results of the investigation and any action in response to the incident of abuse.

During an interview on a specific day in July 2016, Manager #123 confirmed to the Inspector that the outcome, results, and actions of the home's investigation for the CI were not submitted to the Director. [s. 23. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the names of all residents involved in the incident were reported to the Director under subsection 23 (2) of the Act, with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report.

Inspector #613 reviewed a CI report that was submitted to the Director for an incident of resident to resident physical abuse resulting in injury, which occurred on a specific date in June 2016.

During an interview on a specific day in July 2016, Manager #123 confirmed to the Inspector that only resident #019 was identified on the CI report and that resident #020 was not added due to their unfamiliarity with adding an additional resident to the computer system. [s. 104. (1) 2. i.]

2. The licensee has failed to ensure that the names of a family member, person of importance or a substitute decision-maker of resident #020 involved in the incident was reported to the Director under subsection 23 (2) of the Act, with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report.

Inspector #613 reviewed a CI report that was submitted to the Director for an incident of resident to resident physical abuse resulting in injury, which occurred on a specific date in June 2016. The report did not identify whether resident #020's family member, person of importance or substitute decision-maker was contacted regarding the incident.

During an interview on a specific day in July 2016, Manager #123 identified that they had completed the CI report, and confirmed that the name of resident #020's substitute decision-maker had not been included. [s. 104. (1) 3. iv.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed within one business day of a medication incident where resident #036 was taken to hospital.

A CI report was submitted to the Director by the home regarding a medication error resulting in resident #036 being sent to hospital. RPN student #177 under the supervision of RPN #178 administered a dose of a specific type of medication in error when resident #036 was to receive another medication at another dose. Resident #036 was sent to the hospital for further assessment under the direction of the physician and returned to the home the same day with no change in their medical management.

The CI occurred on a specific day in April 2016, and the home reported the CI to the Director eight days after the incident had occurred, and seven days after the incident should have been reported.

A review of the CI indicated that Manager #121 reported the CI to the Director on a specific day in May 2016. A review of the home's internal investigation included a note dated from April 2016, which was written by Manager #121. The note indicated that RN #138 came to Manager #121's office on a specific date in April 2016 and reported the events of the medication error involving resident #036 during the evening of the previous day. [s. 107. (3) 5.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that a monthly audit was undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies, and that immediate action was taken, if any discrepancies were discovered.

During an interview on a specific day in July 2016, RPN #127 reported to Inspector #163 that they were unsure if monthly audits were completed on the daily narcotic control count sheets. The Inspector completed a review of the Medication Room on a particular unit, and there was no documentation to identify that monthly audits were completed.

Inspector #613 reviewed the home's policy titled "Narcotic Security", last revised October 2012, that identified that an audit of the daily count sheets would be undertaken monthly to determine if there were any discrepancies and immediate action would be taken. The policy had a form titled "Narcotic and Controlled Drug Audit" which the monthly audits were to be completed on.

During an interview on a specific day in July 2016, the Acting DOC and Manager #123, both confirmed that monthly audits were not being completed on the daily narcotic count sheets. [s. 130. 3.]

Issued on this 6 day of January 2017 (A2)

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) : JULIE KUORIKOSKI (621) - (A2)

Inspection No. / No de l'inspection : 2016_435621_0012 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 017970-16 (A2)

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

Report Date(s) / Date(s) du Rapport : Jan 06, 2017;(A2)

Licensee / Titulaire de permis :
ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET, P.O. BOX 3251,
THUNDER BAY, ON, P7B-5G7

LTC Home / Foyer de SLD :
HOGARTH RIVERVIEW MANOR
300 LILLIE STREET, THUNDER BAY, ON,
P7C-4Y7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Myrna Holman

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 ST. JOSEPH'S CARE GROUP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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 ensure residents of the home are protected from abuse by anyone.

Grounds / Motifs :

1. The licensee has failed to ensure the protection of residents from abuse by anyone.

Under O.Regulation 79/10, physical abuse is defined as "the use of physical force by a resident that causes physical injury to another resident".

A CI report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home related to an incident of resident to resident physical abuse that occurred in June 2016.

The Inspector reviewed documentation in resident #015's electronic health record related to incidents of responsive behaviours between their admission date and a specific date in June 2016, when a physical altercation with resident #015 resulted in abuse of co-resident #016.

The first incident of resident #015's responsive behaviours was documented in March 2016, followed by five additional incident notes that identified resident #015's

becoming physically responsive with unidentified co-residents.

The Inspector reviewed resident #015's admission care plan dated from February 2016, and the most current care plan dated in May 2016, related to responsive behaviours. Neither care plan included a responsive behaviour focus or interventions to manage the behaviours. On further review, a 24 hour care plan from February 2016, identified the resident's behaviours as verbal and physical aggression.

Additionally, the Inspector reviewed two consultation notes dated from May 2015. The consultation notes identified the resident's increasing verbal and physical aggression, and difficult behaviour management at that time. The resident was noted to have a history of a specified medical condition. This information had not been transferred to resident #015's care plan.

During interviews with PSW #179 and PSW #180 on a specific date in July 2016, they both stated to the Inspector that there was no reference to responsive behaviours in the resident #015's care plan dated from May 2016. They stated that this resident's care plan should have identified their known triggers and staff's response to this resident's responsive behaviours.

On a specific date in July 2016, PSW #181 informed the Inspector that they were aware of the resident's responsive behaviours since admission. They stated the resident known to demonstrate physical and verbal responsive behaviours, unprovoked. They stated this information would be found in the resident's care plan and kardex, however on review with the Inspector, there was no responsive behaviour information regarding these behaviours found.

The Inspector interviewed PSW #193 on a specific date in July 2016. Although PSW #193 stated they were familiar with resident #015, they were not aware of any responsive behaviours that included previous physical or verbal altercations with co-residents. They stated information related to any behaviours would be in the resident's care plan, and as they were aware there was no information related to behaviours.

During an interview with Manager #126, they stated to the Inspector that the resident's known history of responsive behaviours that included physical aggression toward other residents should have been included in their plan of care to protect resident #016 from abuse.

Non-compliance was also identified during this inspection related to WN #2, LTCHA, 2007, O. Reg. 79/10, s. 53 (4) where the home failed to ensure that for resident #015's demonstrated responsive behaviours, strategies were developed and implemented to respond to those behaviours. (616)

2. Under O.Reg 79/10, sexual abuse is defined as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

Inspector #621 reviewed a CI report that was submitted to the Director on a specific date in April 2016, for an incident of resident to resident sexual abuse.

During a review of the progress notes for resident #030 over a six month period between January and July 2016, Inspector #621 identified nine additional incidents of sexual responsive behaviours between resident #030 and co-residents. Of the nine incidents, six occurred prior to the April 2016, CI which was reported to the Director, and the remaining three incidents occurred thereafter.

During an interview in July 2016, RN #124 reported to Inspector #621 that resident #030 had demonstrated sexual responsive behaviours since their admission to the home. RN #124 also reported to the Inspector that staff utilized strategies to mitigate resident #030's responsive behaviours, including re-direction of resident away from vulnerable residents, and that documentation of these strategies would be found in this resident's care plan in paper copy on their chart, as well as in their electronic health record. When the Inspector inquired if there had been referral to outside resources RN #124 indicated that there was no formal referral process but starting on a specific date in April 2016 the Psychogeriatric Resource Consultant (PRC) began providing services to the Behavioral Support Unit (BSU) and staff utilized one page handouts from the PRC that offered strategies on how to manage this resident's behaviours.

Inspector completed a review of resident #030's plan of care, including their chart and written care plan and found no strategies care planned for managing this resident's sexual responsive behaviours.

RN #124 reviewed the most current care plan dated in July 2016, and reported that both the hard copy and electronic version of resident #030's care plan did not include any documented strategies for managing this resident's responsive behaviours. Additionally they identified there was no information on responsive behaviour strategies from PRC on the chart for staff to refer to.

During an interview on in July 2016 with the PRC, they identified that they were a contract service provider and started in their role on a specific date in April 2016. They indicated that they had not yet provided any documented strategies for managing resident #030's responsive behaviours as part of this resident's plan of care.

During a review of the home's policy titled, "Zero Tolerance of Abuse and Neglect of Residents - Reporting and Notifications about Incidents of Abuse and Neglect – LTC 5-51", last revised February 2016, identified that staff members who had witnessed or suspected alleged incidents of resident abuse or neglect were to immediately report to the Director/designate, and/or the VP Seniors' Health, who would then notify the Ministry of Health and Long-Term Care (MOHLTC) by phone and initiate an investigation.

During an interview in July 2016, Manager #123 identified to Inspector #621 that it was their expectation that any suspected incidents of abuse be reported by staff as per the home's policy, which included forwarding an email notification of the incident to the Manager, who would to then report it to the MOHLTC.

Manager #123 reviewed the documentation for resident #030 and confirmed to the Inspector that the sexual inappropriate behaviours as reported by staff from documentation between January and July 2016, constituted suspected sexual abuse and that the incidents were not reported by staff as per home's policy. Additionally, Manager #123 reviewed resident #030's most current written plan of care and confirmed that care planning for sexual responsive behaviour management had not been completed.

Additionally, the home failed to protect residents from abuse by resident #030 as evidenced by non-compliance identified during this inspection related to:
WN #2, LTCHA, 2007, O. Reg. 79/10, s. 53 (4) where the home failed to ensure that for resident #030's demonstrated sexual responsive behaviours, strategies were developed and implemented to respond to those behaviours;

WN #3, LTCHA, 2007, s.6(1)(a) where the home failed to ensure that there was a written plan of care that set out the planned care for resident #030's sexual responsive behaviours; and
WN #7, LTCHA, 2007, O. Reg. 79/10, s.20 (1) where the home failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with. (621)

3. Inspector #621 reviewed a Critical Incident Report (CI) that was submitted to the Director for an incident of resident to resident physical abuse resulting in injury, which occurred in the summer of 2016. It was documented that resident #020 and #019 were separated and PSW #166 then reported the incident to RN #124, who assessed resident #019's injury and initiated the incident reporting process.

On review of resident #020's progress notes over a six month period between January and July 2016, Inspector #621 identified 25 incidents of responsive behaviours.

Of the 25 incidents, four were specific to interactions between resident #020 and #019 that occurred on three dates in June and July 2016. In all four incidents, resident #020 was identified as the aggressor, and in two of these incidents which occurred during June and July 2016, injury to resident #019 was documented with subsequent critical incident reports submitted to the Director.

During an interview in July 2016, PSW #148 and RN #124 reported to the Inspector that resident #020 exhibited responsive behaviours, and resident #019 was a trigger for resident #020. PSW #148 and RN #124 indicated that they utilized strategies to mitigate responsive behaviours for resident #020.

When Inspector #621 asked PSW #148 about what forms of documentation were kept of staff monitoring resident #020's responsive behaviours, it was reported that they were not aware of any formal documentation except when an incident occurred which would be added to the progress notes.

A review of the home's policy titled "Responsive Behaviours Program - LTC 3-50", last revised March 2016, referred to an accompanying document titled "Long-Term Care Responsive Behaviours Toolkit", last revised May 2016, which identified that a

key aspect of resident care included prevention or minimization of situations in which a resident exhibited responsive behaviours. As part of the prevention strategies the toolkit identified that assessment included utilization of screening tools such as the Dementia Observation System (DOS), and documentation of observations was to be found in the resident chart and progress notes.

On a specific date in July 2016, Inspector #621 reviewed resident #020's documentation and identified DOS charting had occurred for the period of one week in July 2016, but the DOS record was incomplete. Additionally, no DOS records were found between January and July 2016, when 25 incidents of responsive behaviours were identified by staff.

During an interview in July 2016, RN #124 identified that DOS charting could be initiated by staff at any time, and that a specific request for DOS charting for resident #020 was made by Manager #123 for a one week period in July 2016.

On review of resident #020's documentation, RN #124 reported that a DOS was initiated for one week in July 2016, but identified to the Inspector that the DOS record was incomplete. Additionally, RN #124 identified that no DOS charting had been completed as part of the home's monitoring of resident #020's responsive behaviours between January and July 2016 when 25 incidents of responsive behaviors were documented to have occurred.

During an interview on July 18, 2016, Manager #123 identified that it was their expectation that as part of responsive behaviour monitoring of residents, that DOS charting of residents was to be completed for those residents, including resident #020 with known responsive behaviours.

On review of resident #020's documentation, Manager #123 confirmed that DOS charting was not completed as part of monitoring this resident's responsive behaviours in spite of 25 incidents identified in the documentation since the first quarter of 2016. Of those 25 incidents, four occurred between resident #020 and #019 between June and July 2016, and two of those four incidents resulted in injury. Additionally, Manager #123 identified that when DOS charting was initiated to monitor resident #020's responsive behaviours for one week in July 2016, it was found incomplete.

Inspector #621 reviewed resident #020's care plan and identified that there were no

care plan updates after May 2016, in spite of there being two critical incidents reported to the Director for responsive behaviours between resident #020 and #019 causing injury to resident #019.

On review of care planning for resident #020, Manager #123 identified that the most current written care plan for resident #020 was dated on a specific date in May 2016. Consequently, Manager #123 identified that in addition to lack of documented monitoring, care planning for responsive behaviour management for this resident had not been updated at any time after the two critical incident reports were submitted in June and July 2016 between resident #020 and #019, and confirmed that the home failed to protect resident #019 from further incidents of abuse following the June 2016 incident.

Additionally, the home failed to protect resident #019 from abuse by resident #020 as evidenced by non-compliance identified during this inspection related to:
WN #2, LTCHA, 2007, O. Reg. 79/10, s. 53 (4) where the home failed to ensure that for resident #020's demonstrated responsive behaviours, strategies were developed and implemented to respond to those behaviours; and
WN #7, LTCHA, 2007, O. Reg. 79/10, s.20 (1) where the home failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Non-compliance pursuant to LTCHA, 2007 S.O. 2007, s.19(1) has been previously issued under inspection report 2015_333577_0012, including a compliance order served October 29, 2015.

The decision to issue this compliance order was based on the scope of this issue, which involved a pattern of multiple co-residents affected; the severity which identified that actual harm occurred; and the compliance history, which despite previous non-compliance has continued in this area of the legislation. (621)

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

Dec 31, 2016(A1)

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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(a) the behavioural triggers for the resident are identified, where possible;

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee shall ensure that:

a) Strategies are developed for monitoring of resident #015, #020 and #030 by staff that will ensure that residents in the home are protected from abuse and that interactions and/or altercations between these residents and others does not escalate;

b) Strategies are developed to mitigate resident #015, #020 and #030's inappropriate physical and/or sexual responsive behaviours, which considers psychological, pharmaceutical, behavioural and physical interventions. Strategies along with resident responses are to be documented in the plan of care; and

c) A process is developed for ensuring the plan of care, including the written and electronic care plans relating to responsive behaviours for all residents in the home are reviewed and revised to identify potential triggers, goals of care, and interventions that reflect the residents current care needs.

Grounds / Motifs :

1. The licensee failed to ensure that for each resident that demonstrated responsive behaviours, strategies were developed and implemented to respond to those behaviours, where possible.

Inspector #616 reviewed four CI reports submitted by the home that involved physical altercations between resident #015 and co-residents #016, #018, #029, and #028 in June and July 2016.

The Inspector reviewed the progress notes in resident #015's electronic health record related to all documented incidents of responsive behaviours from the time of their admission to a particular date in June 2016, when a physical altercation between resident #015 resulted in abuse of co-resident #016. A total of six incident notes were identified during this time which reported physical altercations from resident #015 towards unidentified co-residents.

The Inspector reviewed resident #015's admission care plan from February 2016, and the most current care plan dated from May 2016, related to responsive behaviours. Neither care plan included strategies to be implemented in response to

these behaviours. On further review, a 24 hour care plan from February 2016, identified that the resident was known to have demonstrated verbal and physical aggression.

The Inspector found additional information within the resident's documentation related to behaviours. Two consultation notes from May 2015 identified resident #015's increasing verbal and physical aggression and difficult behaviour management. The resident was noted to have a specified medical diagnosis. The Inspector noted this information had not been used to develop any strategies to respond to this resident's responsive behaviours.

During interviews with PSW #179 and PSW #180 in July 2016, they both stated to the Inspector that there was no reference to responsive behaviours in the resident's care plan from May 2016. On a specific date in July 2016, PSW #181 informed the Inspector that they were aware of the resident's responsive behaviours from their admission to the home area which included unprovoked physical and verbal aggression. They stated this information would be found in the resident's care plan and kardex. However on review the care plan and kardex, the PSW stated there was no responsive behaviour information found.

The Inspector also interviewed PSW #193 on a specific date in July 2016. Although PSW #193 stated they were familiar with resident #015, they were not aware of any responsive behaviours that included previous physical or verbal altercations with co-residents. They stated information related to any behaviours would be in the resident's care plan, and as they were aware there was no information in this resident's care plan related to behaviours.

The Inspector reviewed the home's policy titled "Responsive Behaviour Program", last revised March 2016, which referred to the home's Responsive Behaviour Toolkit, last revised May 2016. This toolkit stated that interventions were developed in the resident's plan of care to minimize responsive behaviour triggers, provide effective staff response for specific residents, to minimize the risk of altercations, and prevent the escalation of potentially harmful or abusive situations.

During an interview with Manager #126 they stated to the Inspector that the resident's known history of responsive behaviours that included physical aggression toward other residents, with strategies for staff to address the responsive behaviours should have been included in their plan of care and was not. (616)

2. Inspector #621 reviewed a CI report that was submitted to the Director for an incident of resident to resident physical abuse that occurred on July 2016, between resident #020 and #019, which resulted in injury to resident #019.

During a review of documentation for resident #020 between January and July 2016, Inspector #621 identified 25 incidents of responsive behaviours, four of which were incidents of responsive behaviours between resident #020 and #019 where resident #020 was the aggressor. See WN #1, finding 1 for further information.

During interviews with RN #124 and PSW #148 on a specific day in July 2016, they indicated that resident #019 was a trigger for resident #020, and that incidents between these two residents had occurred since resident #019 had a room reassignment in June 2016.

When the Inspector asked PSW #148 what forms of documentation were kept to identify that staff were monitoring resident #020 for responsive behaviours, it was reported that they were not aware of any formal documentation except for when an incident occurred, it would be added to the progress notes.

Inspector #621 reviewed resident #020's most current care plan from May 2016, which documented responsive behaviours under the Behaviour Problems focus, however there had been no care plan updates after May 2016, in spite of two critical incidents reported to the Director for altercations between resident #020 and #019 causing injury to resident #019. Additionally, there were no strategies care planned for to identify resident #019 as a known trigger for resident #020 and how to manage this.

A review of the home's policy titled "Responsive Behaviours Program – LTC 3-50", last revised March 2016, referred to an accompanying document titled "Long-Term Care Responsive Behaviours Toolkit", last revised May 2016, which identified that a key aspect of resident care included prevention or minimization of situations in which a resident exhibited responsive behaviours. As part of the prevention strategies the toolkit identified that assessment included utilization of screening tools such as the Dementia Observation System (DOS), and documentation of observations was to be found in the resident chart and progress notes.

On a specified date in July 2016, Inspector #621 reviewed resident #020's documentation and identified DOS charting had occurred for one week in July 2016, but that the DOS record was incomplete. Additionally, no DOS records were found between January and June 2016, when 25 incidents of responsive behaviours were documented by staff.

During an interview in July 2016, RN #124 identified that DOS charting could be initiated by staff at any time, and that a specific request for DOS charting was made by Manager #123 on a specific date in July 2016 to begin that day and for a one week period.

In an interview, RN #124 reported that a DOS was initiated for one week in July 2016, as requested by Manager #123, but identified to the Inspector that the DOS record was incomplete. Additionally, RN #124 identified that no DOS charting had been done to monitor resident #020's responsive behaviours between January and July 2016, when 25 incidents of responsive behaviors between resident #020 and co-residents were documented to have occurred.

During an interview on a specific date in July 2016, Manager #123 identified that it was their expectation that as part of responsive behaviour monitoring of residents, strategies including DOS charting would be completed on those residents, including resident #020 with known responsive behaviours. Additionally, Manager #123 expected that strategies to mitigate this resident's physically responsive behaviours would be documented in this resident's care plan and kept current. On review of resident #020's chart, Manager #123 confirmed that DOS charting was not completed in spite of numerous incidents reported in the documentation, and DOS charting that was directed by them to be completed between specific dates in July 2016, was found incomplete. (621)

3. The licensee has failed to ensure that for each resident that demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Inspector #621 reviewed a CI report that was submitted to the Director for an incident

of resident to resident sexual abuse which occurred in April 2016. In addition to this CI, Inspector #621 reviewed this resident's documentation over a six month period between January and July 2016 and identified six additional incidents of sexual responsive behaviours reported to have occurred by resident #030 towards co-residents. See WN #1, finding 2 for further details specific to incidents identified in resident #030's documentation.

During an interview with RN #124, they indicated to Inspector #621 that staff utilized a number of strategies to mitigate resident #030's sexual responsive behaviours.

When the Inspector asked where staff would find information on strategies used to mitigate sexual responsive behaviours, RN #124 indicated that the resident's care plan found on their chart and the electronic health record would provide this information.

Inspector #621 reviewed resident #030's written plan of care, including the resident's care plan, last revised in July 2016, and found no strategies identified by RN #124.

RN #124 reviewed the most current care plan from July 2016, and reported that both the hard copy and electronic version of resident #030's care plan did not include any documented strategies for manage this resident's sexual responsive behaviours.

A review of the home's policy titled "Responsive Behaviours Program – LTC 3-50", last revised March 2016, referred to an accompanying document titled "Long-Term Care Responsive Behaviours Toolkit", last revised May 2016, which identified that a key aspect of resident care included prevention or minimization of situations in which a resident exhibited responsive behaviours. As part of the prevention strategies the toolkit identified that assessment included utilization of screening tools such as the Dementia Observation System (DOS), and documentation of observations was to be found in the resident chart and progress notes.

On review of resident #030's chart, RN #124 reported that no DOS charting had been done to monitor resident #030's sexual responsive behaviours between January and July 2016 in spite of incidents documented by staff during this time.

During an interview on a specific date in July 2016, Manager #123 identified that it was their expectation that as part of responsive behaviour monitoring of residents, strategies including DOS charting would be completed on those residents, including

resident #030 with known responsive behaviours. Additionally, Manager #123 expected that strategies to mitigate this resident's sexual responsive behaviours would be documented in this resident's care plan. On review of resident #030's documentation, Manager #123 confirmed that DOS charting was not completed and a care plan for sexual responsive behaviours had not been completed.

The decision to issue this Compliance Order was based on a pattern of residents who demonstrated physical and sexual responsive behaviours and who did not have strategies developed, or assessments and reassessments completed and implemented to respond to those behaviours; the scope of the responsive behaviours which affected multiple residents; the severity which indicated actual harm to residents occurred; and the compliance history, which identified non-compliance issued including a Voluntary Plan of Correction (VPC) for inspection 2016_246196_0006 on March 29, 2016. (621)

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

Dec 31, 2016(A1)

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
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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 6 day of January 2017 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JULIE KUORIKOSKI - (A2)

Service Area Office /
Bureau régional de services : Sudbury