Court File No. DC-24-00000007-00JR

ONTARIO
SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

B E T W E E N :

THE ONTARIO HEALTH COALITION and CATHERINE PARKES

Applicants

- and -

ONTARIO MINISTER OF LONG-TERM CARE

Respondent

AFFIDAVIT OF NATALIE MEHRA
(SWORN APRIL 18, 2024)

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1. I, Natalie Mehra, of the City of Oshawa, in the Province of Ontario, **MAKE OATH AND SAY**:

2. I have been the Executive Director of the Ontario Health Coalition since September 2000, as such I have direct knowledge of the matters to which I depose in this affidavit. Where the information in this affidavit is not based on my direct knowledge, but is based upon information and belief from other sources, I have stated the source of that information and I believe all that information to be true.

Background - The Ontario Health Coalition

3. The Ontario Health Coalition ("the Coalition" or "OHC") has a long history of public interest advocacy on matters of health care policy, programs, and law that dates from the early

1980s, including having participated in the consultations that lead to the passage of the *Canada Health Act* in 1984. The Coalition has been deeply engaged in public interest advocacy concerning Canadian health care ever since.

4. The Coalition is comprised of a Board of Directors, committees of the Board as approved in the Coalition's annual Action Plan, Local Coalitions, member organizations and individual members. Currently the Coalition represents more than 500 member organizations and a network of Local Health Coalitions and individual members. We represent more than 750,000 Ontarians, and our members include: seniors' groups; patients' organizations; trade unions; nurses and health professional organizations; physicians; physician organizations; non-profit community agencies; ethnic and cultural organizations; residents' and family councils; retirees; poverty and equality-seeking groups; women's organizations, and others.

5. The Coalition's Board of Directors includes physicians, the Ontario Nurses' Association, patient advocates, trade unions, academic experts in health policy, and leaders of community organizations all of whom share a commitment to preserving and strengthening the policies, programs of Canada's publicly funded health care system.

6. The Coalition is a non-partisan public interest group whose primary goal is to protect and improve our public health care system. The Coalition works to honour and strengthen the principles of the *Canada Health Act* which ensure that health care is provided to all Canadians based on their needs, not their ability to pay. It is led by our shared commitment to core values of equality, democracy, social inclusion and social justice; and by the five principles of the *Canada Health Act*: universality; comprehensiveness; portability; accessibility, and public administration.

7. The Coalition empowers the members of our constituent organizations to become actively engaged in the making of public policy on matters related to our public health care system and healthy communities. Through public education and support for public debate, we contribute to the maintenance and extension of a system of checks and balances that is essential to good decision-making. The Coalition is an extremely collaborative organization, actively working with others to share resources and information.

The Work of the Coalition

8. The Coalition is well-known by policy leaders in both Ontario and federal governments. We are routinely invited to provide testimony before legislative or parliamentary committees. We have provided testimony and have proposed amendments to virtually all major Ontario health care policy and legislative initiatives over the last two decades.

9. The Coalition is also recognized for its experience, knowledge and leadership by the media on a wide variety of health care issues, including the decline of hospital capacity and services, the terrible record of long-term care homes in Ontario, and the failures of both to meet the needs of hospital patients designated as requiring an alternate level of care ("ALC"). The Coalition has a record of advocacy on these issues that goes back at least 20 years and includes research reports, public hearings, and consultations on long-term care and home care.

10. The Coalition has also advocated extensively on issues related to long-term care ("LTC"), and often engages with LTC home residents and their families who have problems with the quality of the treatment, care and safety provided in LTC homes. It has established a long-term care committee which includes family councils from across Ontario, leading academics in the long-

term care field, health professionals, the Ontario Nurses' Association, unions, physicians, faith organizations, patient advocates and others. The Coalition has researched and published reports concerning the state of Ontario's long-term care homes for at least three decades and has advocated for improved hours of care, mandatory minimum levels of care, better infection control and disease prevention, more frequent inspections and for effective enforcement of care standards. It reports on access to care, quality, safety and care levels and the ownership and staffing factors that impact these.

Consultations Regarding the Orchard Villa Long-Term Care Home Licence and Bed Expansion

July 15, 2021 Teleconference Consultation

11. In or around the summer of 2021, I learned that the Ministry of Long-Term Care ("MLTC") was considering an application by Southbridge Care Homes Inc. ("Southbridge") for a new 30-year licence and an 87-bed expansion at Orchard Villa, in Pickering, Ontario. Given the abysmal history of Orchard Villa, and the scale of suffering and death that impacted residents including during the COVID-19 pandemic, the OHC and I were very concerned about the proposed licence and bed expansion. I also knew that many residents' families were concerned, and wanted to have their concerns and views heard and considered by the Ministry in the licensing process given the grave and serious impact this licensing decision has on the lives and wellbeing of current and future residents of Orchard Villa.

12. On July 15, 2021, I participated in a teleconference consultation run by the Ministry regarding the licensing process. I participated on behalf of the Coalition, and my comments and submissions reflected the position and views of the Coalition.

13. The Ministry representative opened the public consultation by giving participants incorrect information. She told people that they had to focus their input on the presentation that Southbridge Care Homes made regarding their proposal for a new building and expansion. However, the consultation was actually a consultation regarding Southbridge's application for a new license, which is not only for a building and expansion, but also for the operation of the facility for up to 30-years, and for the care of its residents. Throughout the consultation, participants were forced to modify their questions to try to fit into the framing as required by the Ministry representative. Although participants had some opportunity to ask questions, the Ministry representative repeatedly told people to restrict their questions and comments to Southbridge's proposal for the facility itself, and used her position as moderator to try to prevent or restrict people from asking and commenting about Southbridge's record in operating the home and caring for residents. The Ministry representative went so far as to tell people they could not ask questions about staffing levels, arguing down and cutting off participants who were trying to ask questions.

14. These problematic interventions from the Ministry representative continued until I had my turn to ask a question more than 45 minutes into the hearing, at which point I intervened and said the information given by the Ministry representative was incorrect and that the Ministry should not be trying to control out people giving input on Southbridge's record and its fitness to be granted a license and operate the home. I then asked a question about what responsibility Southbridge takes for what happened under the current license and whether it would make any concrete commitment at all regarding hours of care per resident going forward. While this is vital information, and critical to the issue of how Orchard Villa would be run in the future, the Ministry representative cut off the discussion enabling the Southbridge representative to avoid answering my question. To date, I

have never received a response from Southbridge, or the Ministry to this question about hours of care per resident.

15. Following my intervention, Jane Meadus, a lawyer from the Advocacy Centre for the Elderly had her turn and reiterated that the hearing was about the license, and under the *Fixing Long-Term Care Act*, the scope of issues under consideration is not restricted to the design of the building.

16. In addition to the Ministry representative's interference with the content of the consultation, many people who were in the queue on the teleconference were never heard as the phone system was apparently not working properly. Subsequent to the consultation, I became aware of at least five people who repeatedly tried to get into the queue and could not be heard. Others hung up and tried to dial back in but could not get back into the call at all. I believe these restrictions also resulted from limitations on the call arranged by the Ministry.

17. I have reviewed the notes of this public consultation at Tab 94V of Volume 22 of the Record of Decision. Partial notes and summaries of my comments and questions during the teleconference consultation appear in Tab 94V, at p. 7020 of the Record of Proceedings.

18. A partial recording of the teleconference consultation made by a volunteer for the OHC is marked as **Exhibit "A"** to this affidavit. Unfortunately, the first 20 minutes of the consultation were not recorded because the volunteer had not initially planned on recording the consultation.

19. Following the teleconference consultation, the Coalition received several emails from would-be participants who, despite their repeated efforts, were unable to participate in the call. To

my knowledge no effort was made by the Ministry to subsequently contact them, or to provide them with an opportunity to ask questions of the Ministry or Southbridge representatives. Copies of some of the emails received by the Coalition are marked as **Exhibit "B"** to this affidavit.

20. Due to the serious flaws in the consultation, I wrote to the Minister of Long-Term Care, Rod Philips, as well as to various Ministry officials, to express my concerns about the lack of a fair and open hearing and asking for the Ministry to reconvene the hearing so that all who wished to do so could participate. A copy of my July 26, 2021 letter is marked as **Exhibit "C"** to this affidavit.

21. Subsequent to the teleconference consultation, the OHC submitted two emails to the Ministry dated July 27, 2021 and August 26, 2021 attaching petitions from members of the public opposed to giving a new 30-year licence to Southbridge, and opposed to the expansion of 87 LTC beds at Orchard Villa. The originals of the petitions were delivered to Minister Rod Philips' constituency office. Copies of OHC's emails and petitions are located at Tab 94S of Volume 22 of the Record of Proceedings.

E-Mail Consultation

22. On October 19, 2022, I made a submission to the MLTC written consultation on behalf of the Coalition. A copy of my submission is at Tab 88BBBBBBB of Volume 19 of the Record of Proceedings. My email submission and attachment included a number of hyperlinks which have not been hyperlinked in the version of my submission produced in the Record of Proceedings. As such, a '.pdf' copy of my email submission with the original hyperlinks is marked as **Exhibit "D"** to this affidavit.

23. For ease of reference, I have also included the information available at the hyperlinks sent to the MLTC in my original email below, marked as exhibits to this affidavit as follows:

a. **Exhibit "E":** Transcript of the Long Term Care Covid-19 Commission Meeting with Families of Orchard Villa on Friday, October 23, 2020;

b. **Exhibit "F":** August 31, 2020, Toronto Star article titled, *'Improper use of PPE. Medicine to the wrong patient. Injuries from falls. A look at the problems inside Orchard Villa as COVID-19 deaths climbed'*;

c. **Exhibit "G":** May 27, 2020 Article from DurhamRegion.Com titled, *'It's our worst nightmare:' Report details horrendous conditions at Pickering's Orchard Villa Retirement Residence'*;

d. **Exhibit "H":** A link to the Public Reporting on Inspections at Orchard Villa, and the inspection reports as of October 27, 2022 which included all the inspection reports from 2010-2022, and which have been included in the exhibit; and,

e. **Exhibit "I":** CBC article dated December 18, 2020, titled, '*These nursing home chains have the highest COVID-19 death rates in Ontario, data analysis finds'*;

24. I never received a response to this submission from the MLTC.

25. I found out in December 2023 that Southbridge's application had been approved by a public notice on the MLTC website. Despite participating in the consultation process, no reasons for the decision were provided to either myself or the OHC.

26. I affirm this affidavit in support of the application for judicial review and for no other or improper purpose.

AFFIRMED BEFORE ME by Natalie Mehra of the City of Oshawa, in the Province of Ontario on April 18, 2024 in accordance with O. Reg. 431/20 Administering Oath or Declaration Remotely.

Natalie Mehra

NATALIE MEHRA

Commissioner for taking affidavits

Geetha Philipupillai LSO# 74741S

This is Exhibit “A” referred to in
the Affidavit of NATALIE
MEHRA sworn before me this
18th day of April, 2024

A Commissioner for Taking Affidavits

Recording-Public consultation.m4a

This is Exhibit “B” referred to in
the Affidavit of NATALIE
MEHRA sworn before me this
18th day of April, 2024

A Commissioner for Taking Affidavits

Subject: FW: Orchard Villa conference call

From: **Marie DellaVedova** <mfdellavedova@gmail.com>
Date: Thu, 15 Jul 2021 at 13:14
Subject: Orchard Villa conference call
To: Ontario Health Coalition <ohc@sympatico.ca>

Good afternoon!
I listened to the conference call and can be included as another person who couldn't get through. It was good that the message from callers was overwhelmingly against license renewal for Orchard Villa.
I'll be sure to send in my comments by email as I'm not very confident that there will be a second hearing.
Thanks for working behind the scenes to enable some key callers to get through.
Well done !

Marie DellaVedova

Subject: FW: Not getting through on licensing hearing

From: **Julia McCrea** <juliamccrea@rogers.com>
Date: Thu, 15 Jul 2021 at 13:48
Subject: Re: Not getting through on licensing hearing
To: Ontario Health Coalition <ohc@sympatico.ca>

Hi Riley,
Thanks for responding.
I was not able to get in the question cue despite hitting *1 each time they asked for more questions. I did listen to the whole call in. I could not text you to be conferenced in at the same time as listening in .
Sorry I have sent my comments to the premier and Rod Phillips opposing the licensing application.

Cheers,

Julia McCrea
Pronouns: She/Her
Email: juliamccrea@rogers.com
Telephone: (289) 356-6979

On Thursday, July 15, 2021, 12:56:32 p.m. EDT, Ontario Health Coalition <ohc@sympatico.ca> wrote:

Hi Julia,
Have you been able to get in now? please text me at 647-617-1474
Riley

On Thu, 15 Jul 2021 at 12:31, Julia McCrea <juliamccrea@rogers.com> wrote:

> Hi Natalie,
>
> I have used both #1 and *1 and am not being recognized by the staff answering phones.
>
> Disappointing!
>
>
> # Julia McCrea
> **Pronouns: She/Her**
> **Email: juliamccrea@rogers.com**
> **Telephone: (289) 356-6979**
>

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We are proud of the difference we make and we hope you are too. This work is only made possible by people who care like you. Please do become a member or donate. It matters!
If you can, please CLICK HERE to donate or become a member.

Ontario Health Coalition
15 Gervais Drive, Suite 201
Toronto, ON M3C 1Y8
Facebook
Twitter
Instagram
www.ontariohealthcoalition.ca
416-441-2502

This is Exhibit “C” referred to in
the Affidavit of NATALIE
MEHRA sworn before me this
18th day of April, 2024

A Commissioner for Taking Affidavits

OPEN LETTER

July 26, 2021

Hon. Rod Phillips
Minister of Long-Term Care
Room 436
Main Legislative Building, Queen's Park
Toronto, ON M7A 1A8
By email: rod.phillips@pc.ola.org

Dear Minister Rod Phillips,

We are writing today to urgently insist that you extend the deadline for the decision regarding the issuance of a new license and expansion to for-profit long-term care chain corporation Southbridge Care Homes for Orchard Villa long-term care home in Pickering (Project # 21-026). We are also asking that you act immediately to correct the criteria your Ministry is using in evaluating this project and in consulting on this license. The way your Ministry is conducting itself does not accord with the Long-Term Care Homes Act (2007) Section 96,97 & 98. These sections clearly give the power to decide about licenses to you as Minister, and require you to consider the public interest. Section 98 specifically states:

> "A person is only eligible to be issued a license for a long-term care home if…;
> (b) the past conduct relating to the operation of a long-term care home or any other matter or business of the following affords reasonable grounds to believe that the home will be operated in accordance with the law and with honesty and integrity".

We have become increasingly disturbed as we have witnessed the actions of the Ministry of Long-Term Care regarding this license.

- In correspondence from your Ministry considering the issuance of the license you have drawn the criteria being considered so narrowly as to exclude the record of the licensee in operating the home, yet the license is for up to 30-years to build *and operate* the home, and in accordance with the Act, and you are required to consider the operator's record and the public interest. The text of the correspondence from your office is appended at the end of this letter.
- In the public consultation your Ministry representative tried to stop Ontarians from asking questions about the record of Southbridge and its ability to operate the home to acceptable standards, in violation of the criteria set out in the LTC Homes Act as above.
- In a press conference[1] on July 15 you stated that licensing was decided by the Ministry and not by you as Minister. That is untrue. You are expressly named as the decision-maker in the Act and it is not acceptable to duck political accountability for your decision.

To us, this creates a picture that the 'fix is in'; that the criteria and the conduct of the Ministry appear to be designed to exclude what should be the absolute central issue, which is whether it is in the public interest to issue for-profit chain company Southbridge Care Homes a new 30-year license and expansion to operate Orchard Villa and whether the corporation can be entrusted with the care of 320 vulnerable residents given its terrible record not only in that

[1] In the link provided at the 11:56 - 14:47 second mark.

home but across the province. As you know, the for-profit chains had far higher death rates than public and non-profit homes, and among the for-profits Southbridge's record is the worst.

We are calling on you to re-do the public consultation in accordance with the Long-Term Care Homes Act. We were participants in and witnessed the entire consultation on July 15. The Ministry representative opened the public consultation by giving participants incorrect information. She told people that they had to focus their input on the presentation that Southbridge Care Homes made regarding their proposal for a new building and expansion. This is incorrect information. The consultation was supposed to be on the new *license*, which is not only for a building and expansion, but also for the *operation* of the facility for up to 30-years and for the care of its residents. Participants were forced to modify their questions to try to fit into the framing as required by the Ministry representative. During the questions, the Ministry representative repeatedly told people to restrict their questions and comments to Southbridge Care Homes' proposal for the facility itself, and used her position as moderator to try to limit people from asking and commenting about Southbridge's record in operating the home and caring for residents. The Ministry representative went so far as to tell people they could not ask questions about staffing levels, arguing down and cutting off participants who were trying to ask questions.

This continued until I had my turn to ask a question more than 45 minutes into the hearing, at which point I intervened and said the information given by the Ministry representation was incorrect and, respectfully, the Ministry should not be trying to control out people giving input on Southbridge's record and its fitness to be granted a license and operate the home. Following my intervention, lawyer Jane Meadus from the Advocacy Centre for the Elderly had her turn and reiterated that the hearing was about the license, and under the Act, it is clear that the scope of issues under consideration is not restricted to the design of the building. I asked a question about what responsibility Southbridge takes for what happened under the current license and whether it would make any concrete commitment at all regarding hours of care per resident going forward. This is vital information but the Ministry representative cut off the discussion enabling the Southbridge representative to avoid answering.

All of the people that tried to ask questions but were limited prior to our intervention by the Ministry representative should be allowed to ask their questions and make their comments on the public record in a proper hearing. They should be allowed to ask and comment about the record of Southbridge and their plans regarding operating the facility, not just building it.

In addition, many people who were in the queue were never heard as the phone system was apparently not working. We have heard from at least five people who repeatedly tried to get into the queue and could not be heard. Others hung up and tried to dial back in but could not get back into the call at all.

This is wrong. Since the Ministry moderator gave incorrect information and since we have documented the testimony of people who could not get into the queue to be heard, we are asking you as Minister to extend the deadline and hold another hearing to hearing with the proper criteria under consideration and enabling all who want to give testimony to do so.

Further, in the consultation hearing held by the Ministry, I asked the Southbridge representative if Southbridge intends to continue to contract out the operations of its homes to a second for-profit company, as it has used the licenses issued by our government (and infrastructure paid by public funds) as its own assets for profit and then contracted out the operations of its homes to for-profit chain Extendicare. Southbridge claimed it has not currently contracted out the operation of the home to another for-profit company and intimated that it will not do so going forward. They claimed that Southbridge and the local public hospital Lakeridge Health had taken over the management, an arrangement that was temporary from months ago. When challenged on this, they claimed that Southbridge is running the home now, something that is disputed by families of residents currently in the home, and which does not accord with our own experience having been recently contacted in writing by a HR manager who contacted us as a representative of the home and whose signature line indicates that she is an employee of Paramed,

Extendicare's home care division. It also does not accord with Extendicare's website which lists Orchard Villa as a home that they operate.

Finally, as you must be aware, the families are not only objecting based on the vast number of deaths and the record of horrific neglect in the pandemic. In the thirteen months from May 26, 2020 to Jun 29, 2021, there were fourteen inspections carried out at Orchard Villa. These inspections resulted in:

- 45 Written Notifications
- 26 Voluntary Plans of Corrections
- 7 Compliance Orders

This is awful, and many of these are major violations like keeping residents safe from abuse, failing to follow care plans, lack of PPE, failing to keep equipment in good repair, assessments not being completed after falls, failing to provide assessments for skin breakdowns/wounds, failing to insure that drugs are not given to residents unless they are prescribed to them, etc.

The text of the correspondence that your office is sending to people who contact you is appended below. In it you will see that the criteria listed for consideration expressly excludes the public interest and the record of the home as quoted above as required criteria under Sections 96,97 and 98 of the Long-Term Care Homes Act (2007).

In close, this issue should not even be under consideration. If Southbridge is able to not only get a new license but also an expansion at Orchard Villa where they were supposed to protect the vulnerable residents and care for them and where more than 70 residents died of COVID and others died of dehydration, malnutrition and horrific neglect, what kind of record would be bad enough for a corporation to be denied a license in Ontario? At the very least, you as Minister must be honest with the public about your duty under the law which requires you to decide what licenses are issued and that you consider the public interest, and that your Ministry consider the record of the licensee. At the very least you must allow those people who were cut off and cut out in the public consultation to be heard.

I will be following up with your office for your response.

Kind Regards,

Natalie Mehra
Executive Director

cc. Brian Pollard, Assistant Deputy Minister, Long-Term Care Capital Development
Hindy Ross, Director, Capital Planning
Wendy Ren, Director, Capital Program Management
Janet Hope, Assistant Deputy Minister, Long-Term Care Policy
Kelci Gershon, Director, Long-Term Care Policy and Modernization

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Subject: Response from the Ministry of Long-Term Care (ref: 245-2021-3799)
Date: Thu, 15 Jul 2021 20:16:18 +0000
From: "MLTC Correspondence Replies (MLTC)" <Replies.MLTC@ontario.ca>
To: Jules Tupker

The constituency office of the Honourable Rod Phillips forwarded your email of July 14 to the Ministry of Long-Term Care regarding Orchard Villa Long-Term Care.

At this time, no decision has been made on the issuance of a new 30-year licence to Orchard Villa. Only after all activities have been completed as part of the licensing review can the Director under the Long-Term Care Homes Act make a decision to issue a licence or licence undertaking. This includes taking into consideration the comments received as part of the public consultation process.

The ministry considers a number of criteria when selecting which projects to approve, including:

- Financial viability and stability;
- Project readiness, including certainty regarding zoning, servicing, land acquisition and intention to complete construction by 2025;
- Upgrading older homes in response to lessons learned around improved infection prevention and control, particularly the elimination of three- and four-bed rooms;
- Providing spaces for Francophone and Indigenous residents, as well as other cultural and linguistic communities;
- Promoting campus of care models and addressing the growing number of seniors requiring specialized and complex care services;
- Geographic diversity to address the varying long-term care needs across the province, including areas with significant demand and rural or remote communities.

The projects that best meet the ministry's evaluation criteria are provided an allocation. Many of these projects will be delivered by the not for-profit and municipal sectors, which account for 63 per cent of new spaces allocated and 34 per cent of redevelopment spaces allocated.

The ministry's evaluation process prioritizes redevelopment of older homes to implement the lessons learned on improved infection prevention and control measures, particularly the elimination of three and four bed ward rooms in which isolation and cohorting has proven difficult.

New spaces built to modern design standards will help prevent and contain the transmission of infectious diseases and ensure residents have access to the care they need in a safe and secure environment.

Thank you for writing.

Sincerely,

Ministry of Long-Term Care

This is Exhibit “D” referred to in
the Affidavit of NATALIE
MEHRA sworn before me this
18th day of April, 2024

A Commissioner for Taking Affidavits

Submission to Ministry of Long-Term Care Public Consultation on New License & Expansion for Southbridge Care Homes Orchard Villa

To: The Director under the *Fixing Long-Term Care Act, 2021*
Ministry of Long-Term Care
Capital Planning Branch
438 University Avenue, 8th Floor
Toronto, Ontario M5G 2K8
Via email: LTCHomes.Licensing@ontario.ca

From: Ontario Health Coalition

Re: PROJECT #23-034 Orchard Villa , Southbridge

Date: October 19, 2022

Under Ontario's long-term care legislation, "A person is only eligible to be issued a license for a long-term care home if... the past conduct relating to the operation of a long-term care home or any other matter or business of the following affords reasonable grounds to believe that the home will be operated in accordance with the law and with honesty and integrity".

The law sets out eligibility criteria including:

- that the home and its operation would comply with the legislation and the regulations;
- that the past conduct relating to the operation of a long-term care home affords reasonable grounds to believe that the home will be operated in accordance with the law and with honesty and integrity;
- it has been demonstrated that the applicant is competent to operate a long-term care home in a responsible manner;
- the past conduct relating to the operation of a long-term care home affords reasonable grounds to believe that the home will not be operated in a manner that is prejudicial to the health, safety or welfare of its residents.

In light of Southbridge's appalling record at Orchard Villa, it would be unreasonable and contrary to law for the government to find that Southbridge is eligible to be approved for a new license and expansion at Orchard Villa. No reasonable assessment could conclude that Southbridge is competent to operate Orchard Villa, or that its conduct affords reasonable grounds to believe that the home will be operated with honesty and integrity and not in a manner that is prejudicial to the health, safety or welfare of its residents.

Orchard Villa LTC in Pickering Ontario gained widespread notoriety for its appalling record during the COVID-19 pandemic. At least 206 of Orchard Villa's 233 residents contracted COVID-19, along with more than 100 staff. At least 70 residents died. Reports from families of residents, the local hospital, the Canadian Forces and repeated inspections before and since the first wave of the pandemic provide hair-raising accounts of failures to provide sound infection control; dire understaffing; inadequate hydration and feeding; uncleanliness; flies and cockroaches; lack of vital supplies and egregious lack of care.

According to a CBC analysis, for-profit LTC chain Southbridge, which owns Orchard Villa, had the worst record among the for-profits during the pandemic with 9 deaths per 100 residents in homes with outbreaks. Orchard Villa had at least 30 deaths per 100 residents.

Not only was Southbridge's record hair-raising during the first wave of the pandemic, since then, their operating record continues to be extremely poor. In the thirteen months from May 26, 2020 to June 29, 2021, there were fourteen inspections carried out at Orchard Villa. These inspections resulted in:

- 45 Written Notifications
- 26 Voluntary Plans of Corrections
- 7 Compliance Orders

Many of these are major violations related to keeping residents safe from abuse, failing to follow care plans, lack of PPE, failing to keep equipment in good repair, assessments not being completed after falls, failing to provide assessments for skin breakdowns/wounds, failing to ensure that drugs are not given to residents unless they are prescribed to them, and more

After June 29, 2021, even as the consultation on its new license and expansion has proceeded, Southbridge has continued to receive non-compliance notices at Orchard Villa resulting from inspections for critical incidents, complaints and other inspections as follows:

- A Written Notification on August 31, 2021 related to a critical incident for a resident fall and injury.
- 3 Written Notifications and 3 Voluntary Plans of Corrections on March 10, 2022 related to falls, poor food, failure to provide PPE to staff and ensure its use for residents with infectious disease, other breaches of infection control protocols.
- 2 Written Notifications and 2 Voluntary Plans of Corrections on March 16, 2022 related to failure to report an allegation of abuse that resulted in an injury to a resident.
- 2 Written Notifications and 1 Compliance Order on June 8, 2022 related to failure to report an allegation of abuse, failure to meet minimum heating temperatures in January, and another fall that resulted in the residents' death.

Thus, in the most recent year, Orchard Villa has again been found non-compliant repeatedly resulting in escalating enforcement attempts including: another 11 Written Notifications, 5 Voluntary Plans of Corrections and a Compliance Order.

This record of poor care stretches back to when Southbridge bought Orchard Villa from its previous owner, Community Lifecare Inc., in 2015, during what Southbridge's Chairman has called its "acquisition phase". Southbridge does not have a history of operating LTC homes. It purchases and licenses homes in order to draw a return on its investment. As it notes on its website, Southbridge hires a management firm, Extendicare Canada Inc., "to manage the operations of our homes, both before and after redevelopment." Extendicare is a for-profit LTC management company that trades on the TSX. Thus, investors are looking for a return on investment from two layers of Orchard Villa's operations.

Southbridge is currently licensed for 233 long-term care beds at Orchard Villa. That license was initially granted in July 2010 to Community Lifecare Inc. from which Southbridge purchased the home as noted above. Southbridge is now proposing to develop 87 additional long-term care beds "conditionally allocated by the Ministry of Long-Term Care" to be included in the proposed 320-bed development project; and the issuance of a new license with a term of up to 30 years for the operation of 320 new beds at the existing location, following the development.

In summary, the record of care provided by Southbridge at Orchard Villa is appalling. Recorded observations by hospital staff, the Canadian Forces, inspections officers include the following:

- Staffing levels at the home to be 20-25% of the normal complement, garbage "everywhere", "very shocking" personal protective equipment (PPE) practices, and the absence of even rudimentary infection control measures. Just to "stabilize the situation," Orchard Villa required a deep clean costing almost $500,000."
  Source: Ontario's Long-Term Care COVID-19 Commission.

- Poor infection control practices, including improper use of PPE; the presence of cockroaches, flies and rotting food; such inadequate resident care that residents were being left in soiled diapers, experienced falls without the post-fall assessments required by regulation, were the victims of medication administration errors, were not properly hydrated or sat up for meals (increasing their choking risk); a broad lack of medical supplies, including limited and/or inaccessible wound care supplies, linens and soaker pads, or properly functioning oxygen generators and suction units; residents being left on mattresses on the floor to prevent them from getting up and walking; significant shortcomings concerning incident reporting and communication between all levels of staff; and lack of training for staff and "[n]o accountability for staff in regards to upholding basic care needs or best practices".
  Source: Canadian Armed Forces.

- Dire understaffing, poor management, and the absence of infection control procedures at the home, conditions that resulted in extreme weight loss, bed sores, infections and other harms.
  Source: testimony of Orchard Villa families to Ontario's Long-Term Care COVID-19 Commission.

- Routine failure to follow falls protocols – even those resulting in injury and death for residents; failure to report abuse resulting in harm; failure to follow infection control protocols; failure to provide PPE to staff and ensure they use it even in recent months; failure to follow care plans and provide safe clinical care; failure to keep equipment in good operating order and to keep the home heated adequately in the winter.
  Source: Inspection non-compliance reports, Ministry of Long-Term Care.

Given its long-standing record of regulatory non-compliance; its persistent failure to operate the Orchard Villa home in accordance with the law and with honesty; its demonstrable failure to operate Orchard Villa in a competent and responsible manner; and its chronic failure to protect the health, safety and welfare of its residents, the Applicant is clearly not eligible for a license to operate this long-term care home and its application for a license to do so must be denied.

Respectfully Submitted By:

Natalie Mehra
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This is Exhibit “E” referred to in
the Affidavit of NATALIE
MEHRA sworn before me this
18th day of April, 2024

A Commissioner for Taking Affidavits

Long Term Care Covid-19 Commission Mtg.

Meeting with Families of Orchard Villa
on Friday, October 23, 2020

77 King Street West, Suite 2020
Toronto, Ontario M5K 1A1

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 23rd day of October, 2020, 4:00 p.m. to 5:00 p.m.

BEFORE:

The Honourable Frank N. Marrocco, Lead Commissioner;
Angela Coke, Commissioner;
Dr. Jack Kitts, Commissioner.

PRESENTERS:

Cathy Parkes, Families of Orchard Villa Member;
Carolin Wells, Families of Orchard Villa Member;
Fred Cramer, Families of Orchard Villa Member;
Marie Tripp, Families of Orchard Villa Member;
Simon Nisbet, Families of Orchard Villa Member;

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat;
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat;
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat;
Jessica Franklin, Policy Lead, Policy Unit, Long-Term Care Commission Secretariat;

Derek Lett, Policy Director, Long-Term Care Commission Secretariat;
Lynn Mahoney, Counsel to the Ministry of Health and Long-Term Care;
Kate McGrann, Counsel, Long-Term Care Commission Secretariat;
Laurel Reid, Families of Orchard Villa Member;
Lisa Theis, Families of Orchard Villa Member;
Elisabeth Van Sickle, Families of Orchard Villa Member;
Catherine Legere, Families of Orchard Villa Member;
Rob Glen, Families of Orchard Villa Member;
Bill Tobias, Families of Orchard Villa Member;
Pam Townley, Families of Orchard Villa Member;
Cathy Gayman, Families of Orchard Villa Member;
Marion Feeney, Families of Orchard Villa Member;
Veejay Leswal, Families of Orchard Villa Member;
Dorothy Scavuzzo, Families of Orchard Villa Member;
Jessica Boily, Families of Orchard Villa Member;
Pamela Bendell, Families of Orchard Villa Member;

ALSO PRESENT:

McKaya McDonald, Stenographer/Transcriptionist.

-- Upon commencing at 4:00 p.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Good afternoon. Commissioner Jack Kitts has joined us and Commissioner Coke.

Well, are you waiting for anybody else?

CAROLIN WELLS: Cathy is going to moderate, and Simon.

SIMON NISBET: Hello.

CAROLIN WELLS: Simon and Marie, I guess.

LISA THEIS: Simon is here.

CAROLIN WELLS: Oh, yeah. There's Cathy. And Fred is there, yeah.

FRED CRAMER: Yeah.

CAROLIN WELLS: So I think that's everybody then, right?

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

CAROLIN WELLS: Fred, Marie, Simon. Yeah, everybody's here, yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, then if maybe I can just start us off and then your moderator can take over, and we can have this conversation.

As you may or may not know, we did release the first interim report today. We jumped the gun a bit, but we're in a hurry.

We felt a sense of obligation to speak as quickly as we could primarily, I guess, because we were created in the middle of something. It wasn't a situation where something was over and we were looking back at it.

We were created in the middle of it, and we felt the need to make some preliminary recommendations as quickly as we could and then take a more traditional approach. The traditional approach is an investigation and some hearing or proceeding to show the public the results of that investigation and then recommendations.

If you take the traditional approach where the event has already occurred and you're looking back at it, you can take two or two and a half years to see it resolve. And, of course, we didn't think that that would be much good to anybody in a situation where we're in the middle of something. To report that far down the road just seemed not to be a good idea.

So we did report, and I want to thank you for the submissions that we received, which we

did read. But we're not finished. We're just starting, actually.

And so it's really important that we understand your perspective on this because that grounds what we're doing in reality, otherwise we get caught up in a lot of slide decks and aspirational thinking and so on, but we miss the actual reality of what happened.

So we're very grateful for you meeting with us, and we really would like to hear what you have to say. The only couple things is we like to ask questions as we go along, which means we would interrupt with a question. It's not that we're rude. It's just that we find that works better than trying to go back after, at the end of something, and bring people back to something they said and ask them a question. So if that's okay with you, that's the way we would like to proceed.

And secondly, we've allocated the time we've allocated, so if -- probably break for about ten minutes in about an hour or so depending on where we are and where you are and in terms of what you're saying.

So with that, we're ready when you are.

CATHY PARKES: Okay. Thank you. My

name is Cathy Parkes. It's showing as "Catherine," but --

COMMISSIONER FRANK MARROCCO (CHAIR): Hello, Catherine.

CATHY PARKES: Hi.

COMMISSIONER FRANK MARROCCO (CHAIR): Cathy.

CATHY PARKES: Yeah, either one works.

So I'll be the moderator today, and we've actually taken the time to formulate our questions together and scripted it.

But we also are all on the same page so, of course, feel free to ask questions at any time and stop any of us. We're like-minded in our thoughts towards this.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

CATHY PARKES: Okay. So I just wanted to say thank you, first of all, for meeting with us today. Those of us here are just a small representation of a group who goes by the name "Families of Orchard Villa" by way of where our families lived.

We're here representing approximately 250 people all who have been affected by the recent

events in long-term care. Our group was formed out of necessity. As the COVID-19 outbreak was declared at Orchard Villa, we found we were receiving little to no information from the home about our loved ones.

So we gathered on social media and found that together we each brought a bit of information that gave us a larger picture about what was going on in the home.

As the group grew in numbers, we began sharing our stories. And we discovered that, although the finer details would differ, the loss and struggle of our loved ones shared too many similarities.

Our families' stories tell the reality of a severe lack of communication discovering that our loved ones suffered extreme neglect, dehydration, and were denied the right to basic care.

I'm very thankful to be a part of the Families of Orchard Villa group. Together we've decided who will speak here today.

We also have several members of the group who will not be vocal, but they are here with invested interest in these hearings and to support

those of us speaking because that's the kind of group that we've become.

We've read the interim recommendations put out today, and while some of the recommendations you've put forward may overlap with what we are going to say, we feel that it's important and enough that they bear repeating.

We have five speakers who will speak --

(TECHNICAL INTERRUPTION)

Oh, somebody's echoing.

We have five speakers who will speak at various times throughout our presentation, and we welcome any questions that may come up.

Our speakers today our Carolin Wells; Fred Cramer; Marie Tripp; Simon Nisbet; and myself, Cathy Parkes.

So I'll start off, and we're just going to go through, basically, our list of concerns.

COMMISSIONER FRANK MARROCCO (CHAIR): And I just want to say, Cathy, before you -- don't worry if some of it overlaps with what we said because some of what we said overlapped with what other people said.

CATHY PARKES: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR):

And we were just trying to add our voice to that, so don't be concerned about that.

CATHY PARKES: Okay. Thank you. So current regulations indicate that if a resident is not being nourished and hydrated, their power of attorney must be notified, but this regulation was not adhered to during the lockdown.

We feel that almost every death could have had a different outcome if the families and POAs were informed and allowed to send the residents to hospital, which many of us weren't.

We insist that if a resident's health status becomes perilous, the home must inform the POA or caregiver and must send the resident to the hospital regardless of a do-not-resuscitate status.

And next is Carolin Wells.

CAROLIN WELLS: So I'm Carolin Wells. My father was James Shankland Fleming, and he passed away April the 9th of this year at Orchard Villa, obviously, and he was 88 years of age.

So Number 2: We have noticed from observation of our family members and from medical records that many residents have been denied treatment for non-COVID related ailments during the pandemic -- for example, UTIs, bedsores, falls,

scrapes, bruises.

Some of these issues, such as UTIs, have significant impact on an elderly person's health. Others such as bedsores, falls, and bruises highlight the substandard care and attention that was provided particularly during the shutdown.

We recommend that appropriate medical attention -- including access to doctors, treatment, hospitalizations, and notification of POAs -- sorry, that they should not be denied during the pandemic.

CATHY PARKES: And then our next speaker is Marie Tripp.

MARIE TRIPP: Good day. The military report -- and we, the families that have served -- that many infected and dying residents did not receive oxygen due to the fact that the life-saving equipment was not properly maintained.

We recommend that the oxygen be available for every resident should they need it or failing the availability of oxygen that each resident be sent to the hospital to receive care.

CAROLIN WELLS: Okay. So infection control and personal protective equipment: At the

beginning of the pandemic and before the outbreak at Orchard Villa, we observed that there was an absence of infection control procedures at the front door and throughout the building.

The only infection control observed was a table with hand sanitizer and a sign-in sheet in the front lobby that was not monitored. We believe this contributed to COVID being brought into the home. We would like to see contact management and tracing enforced.

CATHY PARKES: Thank you, Carolin.

And next is Simon Nisbet.

SIMON NISBET: Hi. My name is Simon Nisbet. My mother, Doreen Nisbet, resided in Orchard Villa 2017 until May 3rd, 2020, at which time I was able to have her relocated to the hospital where she arrived in very poor health. She is a survivor of Orchard Villa and continues to reside in a long-term care system.

Thank you for meeting with us today.

I'll continue with the infection control and PPE points. Once the pandemic was declared, Orchard Villa should have had plans for isolation.

Once COVID-19 was confirmed in the

home, family members became aware that there was no cohorting or isolation procedures being followed. Family members are aware that COVID-19-positive and negative residents were kept in the same room even though the management of the home claimed they had been separated.

We are asking for a mandate that each long-term care home have a secure, isolated space for residents and track the virus during outbreak. This would also include dedicated staff for isolation wards.

Cathy?

CATHY PARKES: Thanks, Simon. The Ministry of Long-Term Care identified, two years ago, that four-bed rooms were to be done away with. But Orchard Villa has many rooms where residents are living four residents to a room.

We do not feel that this lands itself to a quality of life on its own, and we feel the standards of having four residents to a room led to many infections and, therefore, deaths.

In addition, the rooms that are specified as semi-private are so cramped that often furniture has to be moved to allow a resident to exit the room in their wheelchair.

We would like to see the abolishment of four-bed rooms in all long-term care homes in Ontario as soon as possible.

And now on to Fred Cramer.

FRED CRAMER: Hello. My name is Fred Cramer, and my mother, Ruth Cramer, lived at Orchard Villa from September 3rd, 2019, until her death on April 19th, 2020, due to COVID-19.

After the lockdown on March 14th, residents continued to dine together in large groups. They also continued to congregate in the lobby for entertainment purposes. They continued -- up to and including April 9th, 2020 -- after Orchard Villa had reported the first case of COVID-19 in the home.

We recommend that you will ensure meals be served at multiple settings to obtain proper social distancing guidelines. We also recommend that large gathering for entertainment purposes be restricted when social distancing is not possible.

Carolin?

CAROLIN WELLS: Yeah. Number 8: We observed a consistent lack of social distancing and masking of those smoking outside. We recommend that a separate smoking section be required away

from main entrances and exits as well as hallways.

We recommend that smokers who are COVID-positive be closely monitored and kept at a distance when smoking and/or using common areas to enter or exit the building.

CATHY PARKES: And, Carolin, it's you again, Number 9.

CAROLIN WELLS: We are aware that residents who wander due to their health status were allowed to enter rooms that were not their own therefore raising the potential for spreading the virus.

We feel that there needs to be humane safety protocols for residents who wander especially those who are in a security-controlled ward but are still able to travel to and enter other residents' rooms.

CATHY PARKES: And now we move on to staffing with Fred.

FRED CRAMER: Okay. Prior to the pandemic, we were aware that staffing levels were always below standards. We saw this daily as we visited.

During the beginning of the lockdown, many of us were told by Orchard Villa staff that

they were extremely shorthanded and therefore unable to care for residents in the manner they deserved.

This was especially true during the evening and overnight shifts. We were aware that the residents went without food, hydration, medication, and basic care.

We recommend a standardized plan for staff/resident ratios inside and outside of an outbreak.

And I've got the next one, too, here. We would like to see certified, standardized training for all staff in Ontario including infection control and use of PPE as well as ethics and duty to report.

We'd also like annual retraining to ensure all staff is continuing in their understanding of these protocols.

Carolin?

CAROLIN WELLS: Yeah. So 12: We recommend better quality of employment for staff which includes better pay, benefits, the requirement that a staff member may only work in one home at a time.

We also recommended incentives to

educators that will raise enrollment in necessary long-term care staffing fields such as nursing, personal support workers, nutrition, and physical therapy care.

CATHY PARKES: And, Marie, on to you.

MARIE TRIPP: Okay. I'm sorry. I didn't introduce myself. My name is Marie Tripp. My mother was Mary Walsh. She entered Providence Villa in April 2019, and she passed away April 20th, 2020, from COVID.

Okay. Due to the lack of staffing during the pandemic, we recommend an assessment and comparison between staff scheduling and the staff swipe-card system which will indicate staffing numbers during the pandemic.

In addition, we ask that this information be validated between payroll and the accounts payable system to inform on actual staffing. We would like this information to be made public.

CAROLIN WELLS: Okay. 14 --

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just stop you there for a minute, Ms. Tripp? What you're saying is you want to know who was paid to work when and --

MARIE TRIPP: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- make that so that will tell you how many people were working per shift, et cetera, on the theory that if they paid them, they worked, and if they didn't pay them, they didn't work?

MARIE TRIPP: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

CAROLIN WELLS: So 14: We are aware that doctors rarely entered the home during the pandemic, and if they did, the information they relayed to families was not helpful.

We recommend an assessment of staff physicians to determine if they were on site, and if not, why.

SIMON NISBET: So moving on to information issues. Every family member endured a severe lack of information during the lockdown which was also highlighted in a military report on Orchard Villa.

At best, communications from the home were sporadic and inconsistent, but most often, they were nonexistent, and the information that was conveyed was incorrect often indicating numbers of

infected residents that contained conflicting information that was presented in both the media and on the Durham Region outbreak website.

We recommend a standard of communication between long-term care homes and family during outbreaks. We would like to see one or two staff members whose sole responsibility is to keep the families appraised of their loved ones' health and mental health status including timely phone communications and allowing for video conferencing between family and their loved ones.

This would include ensuring that every home has multiple tablets on hand to provide the necessity. We would like to see this position filled by a third party impartial and separate from the long-term care home staff.

Cathy?

CATHY PARKES: Thanks, Simon. Number 16: We would like to see an assessment of kitchen staffing during the pandemic, food supplies, and distribution of meals to residents during the pandemic, and we would like these assignments to be made public.

Fred?

FRED CRAMER: I have Number 17. Many

of us have obtained our loved ones' charts and have found gaping holes from as early as the lockdown on March 14th, 2020.

We recommend the review of all charts in the charting system at Orchard Villa to determine if standard charting requirements were met. We would like this information to be made public.

And I've got the next one, Number 18.

Not being allowed to see our family members was and continues to be very damaging. We were forced to rely on staff providing this information about our loved ones which was often false.

We recommend that in-room cameras become standard for every resident in long-term care homes which allow family members to have visual contact with their loved ones.

MARIE TRIPP: Number 19, legal: We are aware of some certificates -- I'm sorry. We are aware that some certificates have other causes of death even though the resident was COVID-19-positive.

We would like all death certificates from the beginning of the lockdown to the present

date be reviewed and, where necessary, be revised to include COVID-19 as the cause of death.

Number 20: We're concerned about the documentation and signing off of all death certificates during the pandemic.

It is our understanding that, during the months of March 2020 to present day, there were multiple deaths pronounced by staff that did not hold the required medical licenses to pronounce death.

We recommend the investigation of death certificates and appropriate actions be taken if there are findings that a registered physician or registered nurse did not fill out a certificate.

Simon?

SIMON NISBET: We are aware that residents were not being properly nourished prior to and especially during the pandemic. The military report on the five long-term care homes stated that residents were either not fed or the food or refreshments were placed out of reach of residents.

We were also aware that, prior to the pandemic, Orchard Villa residents' meal budget was $7 a day. That's $2.33 a meal.

We recommend more nutritional meals served according to Canada's Food Guide with an increased meal budget. It should be made mandatory that family be notified immediately if a resident is not consuming food or water to normal standards.

Cathy?

CATHY PARKES: During the pandemic, several family members were banned from being present with their loved ones during their final moments of life, including myself.

We strongly insist that family members be allowed to be present with their loved ones, regardless of COVID status, if the resident is deemed to be at the end of life and, in allowing this, that the home will also provide the family members with full personal protective equipment upon entering the residence.

Marie?

MARIE TRIPP: Yes. Number 23: We were concerned about the high level of personal property loss experienced in long-term care. Wedding rings, personal items, and other valuables were misplaced, never found, or damaged beyond repair. We would like the Commission to address this.

And Number 24: We would like to know

why management of Orchard Villa did not call the Durham Regional Police to advise on each death of a resident as is required by law.

SIMON NISBET: Inspections: We are aware that the amount of RQIs dropped dramatically in 2018 which has allowed long-term care homes to fall below standards of care.

We have also heard statements from long-term care ministers that RQIs are always done without notice to the home. However, we know this not to be accurate.

We recommend the immediate reinstatement of yearly RQIs. Each long-term care home in Ontario should receive at least one or two RQIs annually without the home being advised in advance. These should be comprehensive inspections involving a team of nursing, dietary, and environmental inspectors among others.

We further recommend that inspection reports require follow-up requirements by the Ministry of Long-Term Care inspectors. We would like to see the voluntary plan of correction be removed as a requirement from each home and that stricter responses from each home become mandatory with more effective sanctions to ensure compliance.

Fred?

FRED CRAMER: Funding allocations: We recommended the investigation of how for-profit homes allocate the funds received by the provincial government. We would like this information to be made public.

Simon?

SIMON NISBET: Hygiene:

Thanks, Fred.

We are aware the residents were left in soil garments and bedding for several days at a time even when they did not require these garments prior to the pandemic.

We recommend an investigation into the rise in urinary tract infections and bedsore infections during the pandemic.

As documented through records from the Canadian military, Orchard Villa was experiencing pest control issues in several areas of the home.

We recommend that a standard interval of deep cleaning, pest control, and regular disinfecting of services be adopted. We recommend that the documentation regarding pest control and deep cleaning be made public and that there be a schedule for future deep cleaning and pest control.

The certificate of inspection should be posted in a similar fashion to the restaurant pass system. The certification should be posted for visitors to see.

During the initial shutdown of Orchard Villa, the care received was substandard and led to a further decline of residents' health and cognitive function which fell well below the standards outlined in the Long-Term Care Act of 2007.

We feel that these standards should not be sacrificed during an outbreak. This would include but not be limited to mandatory requirements: that they be turned in their beds regularly to prevent bedsores; daily bed changing; daily cleansing; the ability to be safely toileted; a minimum standard of care for dental hygiene for each resident; a minimum standard for foot care for each resident -- this has been an ongoing problem within and outside of the pandemic time lines -- at minimum, two showers or baths per week; air quality inspections --

Oh, sorry. This is Carolin.

CAROLIN WELLS: That's okay.

CATHY PARKES: That's okay. Simon, did

you want to finish up? That last part was yours, and then Carolin can do the next one.

SIMON NISBET: Oh, I'm sorry. I have a typo here. Air quality inspections implemented weekly or biweekly during outbreaks.

CATHY PARKES: Okay. And then, Carolin, do you want to take the mental health one?

CAROLIN WELLS: Sure. I'll take the mental health. So Number 30: Residents were denied access to the outdoors for weeks or months. This denial increased the feeling of isolation, had negative affects on our family members' health.

We recommend an implementation of resident rotations out of doors for fresh air in a secured environment during outbreaks.

Should I continue there? Yeah?

CATHY PARKES: No. We'll let Simon take that one.

CAROLIN WELLS: Okay.

SIMON NISBET: Thanks, Cathy.

CATHY PARKES: Yeah.

SIMON NISBET: We have witnessed a decline in mental health along with the physical effect it has had on some of our loved ones. Often residents were left in bed for days at a time. The

residents were also denied mental stimulation.

We recommend an assessment and solution to residents enduring months of isolation as well as attempting to place residents in rooms with like-minded residents or those in similar cultural backgrounds.

We would like to see increased support from recreation, social work, or activity staff to address isolations, fears, and related mental health concerns.

And onto residents without advocates -- and I could tell you my mom, on a regular basis, would tell me "if this is like this for me, Simon, what must it be like for people that don't have people coming in?" Some individuals at Orchard Villa have no family or power of attorneys.

We know from experience how important our advocacy efforts and hands-on assistance have been in ensuring that even basic care needs for our family members are and were met.

We recommend that if a resident does not have an immediate family, friend, or power of attorney or a designated contact, that a level of staffing be provided to ensure that these residents' needs are being met.

Furthermore, we recommend the implementation of a group whose sole purpose is to update the residents' well being and the health status in the absence of family, friend, or power of attorney advocate.

Marie?

MARIE TRIPP: Thank you. Retirement living: Although we are speaking to long-term care residents today, we're also mindful that the outbreak in the long-term care side of Orchard Villa had a devastating impact on the Orchard Villa retirement community that is on the west side of the building.

The retirement section of the home was not included in many of the measures that were taken to protect the long-term care residents. We are aware that the staff and residents often commingled between the two sections.

We recommend that, if any long-term care home is housed under the same roof as a retirement home, that all retirement residents and staff be treated with the same urgent care equally. Thank you.

CATHY PARKES: So that's the end of our points. I did also just want to say that my father

was also a resident of Orchard Villa. He went in in November of 2019 and passed away April the 15th, 2020. His name was Paul William Russell Parkes.

So while our real list of concerns is actually quite a bit longer than this, the points that you've heard were spoken because we feel it most urgent and needed immediate action.

We would be remiss if we didn't also speak to our worry that a culture of fear exists among the staff at long-term care homes. This fear put on the staff by owners and management has kept the province from hearing the most important details of what has occurred in our long-term care homes aside from the residents' own stories.

We would like to see long-term care staff being given the respect they deserve and to create an environment where they are free to speak the truth of what they have witnessed.

COMMISSIONER FRANK MARROCCO (CHAIR): Cathy, can I stop you there for a minute?

Do you think they would come forward if they thought there was some confidentiality associated with what they were saying?

CATHY PARKES: Yes. I've actually been approached anonymously in person, though, by staff

who knew my father, who knew the man who shared the room with him. And they had things to say to me that they were just too afraid to say because there are internal documents that are being circulated within the home from management and from owners telling them not to speak even though I believe that's not right.

But, you know, it's worded in such a way that it just implies "you shouldn't be speaking." And yet they really want to speak. I mean, these staff members loved our families. They saw them every day. And to have to watch them die that way was upsetting, and they want to talk, but they're terrified.

COMMISSIONER FRANK MARROCCO (CHAIR): See, that's very interesting to me. We've heard from others, like ONA, that the staff really were fond of the people they were looking after.

And was that generally the impression of the families that are here, that the staff had formed some affection for the people they were caring for?

CATHY PARKES: Yes. And, of course -- everyone's nodding -- there's certain staff members who your family members had a tighter bond with.

And I mean, I was only there for -- my dad was there for five months, and I became friends with the staff members and learned to trust them and talk about their personal lives and created a bond with them. And I could see who my father really connected with.

So yes, it becomes like a -- when you have to leave your family in the care of someone else, you need to build that relationship with them and that bond with them, and oftentimes we did.

COMMISSIONER FRANK MARROCCO (CHAIR): Did anybody notice problems before COVID? I'm interested in the observations of that nature that anyone might have made.

CATHY PARKES: Who wants to go first?

Yeah. I mean, I'll say first that, in the brief time that my father was there, we dealt with chronic UTIs, renal failure due to him not being cleaned properly and changed properly, falls, scrapes, bruises, left without eating for 48 hours, staff to resident abuse that was reported. And I never saw it on an incident report, but I certainly did report it to management. And that was in five months.

I know there are people who have had

family members in there a lot longer than my dad, and it's been going on for quite a long time. I think Carolin could probably speak to that.

Carolin, your mic is off.

CAROLIN WELLS: Okay. There we go. Yes, there were definitely signs, big time. So my dad was admitted April 9th, 2018 -- oh, sorry, no, November 5th, 2018.

And the next day we got a call that he had a lesion on his arm. He fell the day he was admitted.

On November 15th, he fell out of bed, and he hit his right elbow.

November 27th, he had a skin tear on his right hand. He was in the TV room and tried to stand.

He was found out in the parking lot. And my dad could not walk. He was in a wheelchair. He had had a major stroke. So he was found out in the parking lot.

I'll just list three things -- or five things that were quite significant. I put it in my -- you know, when I spoke to you before.

There were allegations of sexual abuse, my father being the victim. I don't have the

details now. My mom's the POA, but she certainly -- it got found -- it was unfounded, but there were allegations of it.

He fell out of the his wheelchair in the shower. There should have been two PSWs in there. There was only one, and he needed a lift, which they did not use.

He had an eye injury here. He needed medical intervention and needed to be sent to the hospital.

And I'll say this: When they go to the hospital, is it scares them. I'm sure you probably know that it scares them. It's different. There's different people around. Just that going and coming is a big issue.

But I'm actually glad he was sent because there's lots of times he should have been sent and he was not, and I'll get to that.

Anyways, and my dad was found in another resident's room one time. My dad was not incontinent, so it bothered him that he had to wear a diaper. They found them in there. His diaper was off, and he had -- if you think of the foot pedals on the bottom of the wheelchair, they can be taken off.

So when they're taken off, there's, like, a steel kind of -- hollow, steel tube. He fell on that, and it went inside him and into his rectum, and he had to go to the hospital and get internal stitches and on his, obviously, outside.

The last one -- and this is very telling -- very telling -- about them being prepared/not prepared. I went to visit him. He had a cough, and he sounded very hoarse. I couldn't understand what it was, and then I heard something about them saying "you know, it might be pneumonia."

I think they finally sent him -- or I can't remember if it was my mom or them. When he got to the hospital, they said he was so dehydrated that when they did the x-ray on his chest, they could not see the pneumonia. They couldn't see the fluid because he was so dry.

He had sores all over his face and his mouth from the dehydration. He was septic, totally -- he was septic, and his kidneys totally shut down.

They said the gunk that came out of him from his urinary tract was unbelievable. I'm amazed that he made it, but he did, and he was back

at Orchard Villa shortly after that. I think it was maybe a couple of months after that when COVID came.

But, you know, to even sit there and wonder whether to send them to the hospital -- I don't understand. A lot of times they put it in the hands of the loved ones, right? And my mom's a pretty quiet person, and she was looking to the doctors to make the decision, and that was an obvious one. He almost died.

CATHY PARKES: Yeah. And we had the same where we weren't told about his UTI until it actually became so serious --

CAROLIN WELLS: Yeah.

CATHY PARKES: -- that he was going into renal failure. And when we speak about -- the dehydration is so prevalent. You know, you walk into a long-term care home, and the temperatures are unbelievably high.

And I understand, in the winter, they're doing this because, you know, you get cold as you get older. You kind of lose some of that body heat. But they're not hydrating them enough to deal with how incredibly -- it's like a sauna in there.

And so my father would often say -- and he was by a window -- that he was just hot, overheated, sweating, and couldn't handle it, but yet they're not bringing them water.

So this is part of the reason -- this and, of course, having to wear, you know, adult garments is the reason why you're dealing with so many UTIs and why a lot of people end up in hospital with dehydration. That seems to happen quite a bit.

Does anybody else want to share their stories about --

Catherine? Unmute.

LISA THEIS: Yes. It's Lisa. Thank you.

CATHY PARKES: Oh, Lisa. I'm sorry. You're --

LISA THEIS: Oh, no, we look a lot alike.

There's three things that happened when my dad was at Orchard Villa. When he went into Orchard Villa in November of 2018 -- he said he was settling in, and at his three month review, we sat with the nurse staff and someone from nutrition and a PSW representative and a nurse.

And we started to discuss Dad's medical condition. And I said, "well, his AFib --" and the nurse looks at me with a blank stare. "I didn't know he had AFib."

And then I said "he also has a condition that when he moves from lying down to standing up or sitting to lying down, his blood pressure drops rapidly." And they said "we don't have that in his file."

So I panicked because the physician had been making medical changes to his pharmaceutical based on the information that they had. So I went back to the table with the nurse after the meeting, and we went through my dad's record that had been transferred over from his GP, and every single medical condition I had spoke to in the meeting was in the report. Nobody had read it.

And the next time I saw the physician in charge, I said "are his records now accurate?" And he looked down and said "yes, they are, ma'am."

Another time I spoke to a nurse because they weren't transferring my dad properly, and she said to me: "I tell them all the time to transfer him by the lift, but they just won't do what I ask."

The other incident was dad got some pressure sores on his bottom because his seat on his wheelchair had deflated. And every day, a PSW was supposed to check that it was still inflated before they put him in his chair. And he had gone two weeks sitting on metal, they figured, because no one had checked to see that his seat was inflated.

So it's the basic -- the very basic things and the very dire things that aren't being looked after. And they just -- I think it goes back to -- once again, it's not that they don't want to do these things. They don't have enough staff.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Thank you. Thank you.

Well, Cathy, were those all the recommendations?

CATHY PARKES: Those were. I just wanted to read the last little part of what we had here.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, sure. Go ahead.

CATHY PARKES: Okay. Our faith has been shaken during the past year. We've had to sit

helplessly as we watched our family members become gravely ill and often die.

To us, this is not a question of where to point fingers or debating on a public forum. This has affected our lives forever.

We know that we must all face the loss of our elderly loved ones at some point, but the grieving that has come with knowing how they died and how they suffered has come at a cost that can't be put into words.

Our sincere hope is that, by speaking, we will somehow affect a change. We appreciate the recommendations you're putting together and that you're doing. And for those that we still have with us, we feel we have to speak for our spouse, for our loved ones, and for our future generations.

Our ultimate and united goal is to see the end of for-profit care in Ontario.

And that's all. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, unless the commissioners have any questions that I didn't ask --

FRED CRAMER: Can I just add a little something about my mom too?

COMMISSIONER FRANK MARROCCO (CHAIR):

Go ahead. Sorry, I didn't mean to cut --

FRED CRAMER: No, I didn't get in there quick enough there. My mom, the first day she went to Orchard Villa, they were not ready for us. And so we had to wait around. And they took my mom down to her room, and they had nobody take her off the gurney to do a patient transfer.

She is in a wheelchair, and she had two people assist. And we waited, and the transport people said they don't normally take the resident off the gurney. But in this case, they did.

My mom, she was laying -- well, actually, the bed wasn't even made. It was just a plain mattress there. So found some sheets. That was a little bit of a chore.

They put her down on the bed. She didn't look too comfortable. We got taken in the office and did her paperwork. And at that time, we said about not giving my mom a flu shot. She had violate reactions, and she was in the hospital for days at a time back years ago. And they had it in the charts, "no flu shot."

I just found out recently she did have a flu shot. Now, luckily it didn't have any reaction -- I don't think so. There's nothing in

the notes.

But just something that was in the notes, "do not give flu shot. She has reactions." But they gave it anyway, and they didn't tell me.

She had three falls as well. She had two falls out of bed, and then the third fall was really bad. She was right in front of the nursing station, and she fell flat on her face and broke the tip of her nose, and it was right in front of the nursing station.

So one question I had: Why couldn't they buckle up the seat belt on the wheelchair? And they said they can't do that because it's a restraint.

I found out later -- and it's in a wheelchair that can be unbuckled like a seat belt in a car -- that it is acceptable. So I think that if she would have had her seat belt on, she probably would not have fallen. And she was in the hospital for about -- I think it was about six or seven months, and the nurses there kept saying "buckle up; buckle up."

You know, so I wondered why in the hospital they stressed to buckle her up, but at Orchard Villa, they said they can't do that.

What else was there? The falls and just the -- at dinner time/lunch time, everybody was crowded. It's just so many people. They just start bumping into each other. The tables are small, and the residents are back to back.

Most people were in wheelchairs, and they didn't have enough room for the wheelchairs to be back to back or even side to side. It was really overcrowded, and that, really, should be one of the things addressed. Either two sitting times, or something has to be done there.

And up to COVID, you know, we saw these things. During COVID, I don't know what happened. I know she did have some bedsores as well that kept continually -- looking after continually. So I don't know if, during COVID, they do that for -- because the staffing levels were less. I'm not sure.

But there were some bonds, I kind of said. We got to know some of the PSWs, some of the nurses. They were great.

Some of the other ones you had to sort of play their game a little bit. They were not very nice, but you had to really sort of do some sort of -- like a little -- click with them, and

then they would help you a bit more.

But just overall, even before COVID hit, there was just, I think, a lack of staffing. That's pretty well about all we know is.

COMMISSIONER FRANK MARROCCO (CHAIR): It's Carolin, is it?

Yeah, you're on -- there you go.

CAROLIN WELLS: Oh, sorry. I was just going to say, too, then they would blame it on the nurses. Like, administration would blame it on the nurses and the PSWs, and they would say "oh, don't to them," you know? And there was a real -- you know, it was from top down. That's what I always say, "top down."

CATHY PARKES: There was a real divide between management and PSW and nursing staff, a real divide, and lack of communication and lack of coordination. That was always a problem.

CAROLIN WELLS: Yes. Like, when my dad fell in the shower and she told me that the PSW was put off work for a week or two without pay, like, she -- Beverley, the director of care, thought that I'd be pleased with that.

I wasn't pleased with that because sure, she shouldn't have done that, but they're

also almost forced to do it, right? Like I said, there's a -- like you guys were saying, there's a climate of fear. Like, they have to get the showers done. If they don't get the showers done, they get in trouble.

I wasn't happy that that woman lost a week's pay when she's probably not getting paid that much. I just wanted my father to be treated the proper way so he wouldn't get hurt. But there was a lot of issues.

And another thing I was going to say, this codex -- am I saying it right? Did everybody find the codex -- was it codex? -- when Lisa was talking -- because my dad had AFib. He had a whole bunch of things.

And you'd ask about it, and they kept telling us "oh, they're supposed to read it before each shift. They're supposed to read that. They're supposed to know about that."

But they didn't. There was tons of times when they didn't. We'd go for meetings, yearly meetings. My dad was freezing the whole time. "Please just put a sweater on him all the time." "Please give him his hanky that's comforting for him, and he's got allergies." But

they just wouldn't follow through. So that's all.

MARIE TRIPP: Sorry, can I jump in for a minute?

COMMISSIONER FRANK MARROCCO (CHAIR): Sure.

MARIE TRIPP: Thank you. Marie Tripp. My mom was Mary Walsh. As stated, she was in there, in Orchard Villa, one year.

In that one year, there was two separate investigations. One led to a nurse being suspended for six months; the DOC, Beverley's assistant, asked to resign; and retraining of all staff. That was on one side.

Mom got transferred at my demand to another wing. Over there, there was still the problems, improper transferring. Mom's getting bruised.

I go to Beverley again. Now, what Beverley investigates -- and blaming the PSWs and the nurses.

She was having them all retrained once again and then deemed my mother a three-person transfer. It was hard enough getting two people, two PSWs. Now Beverley did this, three.

I asked for that to be changed back to

two. She would not do it. I stood outside my mother's room without the people knowing I was there and saying "we can't get anybody else. Nobody wants to come in here. All they do is complain."

So it's the management from there down, as everybody keeps saying. I just had to get that in there because two investigations in one year with suspensions, asking to resign, and then a second one. They just were clearly appeasing myself. That's all they were doing. Thank you.

CATHERINE LEGERE: I just want to say something too. I think my sister, Lisa, spoke to three things that have happened with Dad.

Also, we found that there was an overuse of -- well, considered, I guess, chemical restraints. So Dad didn't always respond in a positive way when he was getting his personal care, and we kept trying to tell them how to engage with him.

He was a very chatty, social person. And if you kind of joked around with him, then you could get him, you know, to engage. Or if you just explained to him what you were doing, he would be fine.

But consistently, we found that that wasn't happening. And what they would do is they were more keen to give him some kind of a tranquilizer or sedative. I'm not sure what it was, but they would give him a medication just to calm him down rather than sort of approach him in a more humane way. That was another problem we had.

CATHY PARKES: If I could just quickly say -- I'm just getting some messages. For those of you who joined but weren't sort of speakers today, yes, please, feel free to speak.

I was being asked if it's okay if everyone speaks. Anyone can.

So, Pamela, if you have something to say...

You might be muted.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I think --

CATHY PARKES: I guess not.

PAMELA BENDELL: Yeah, I'm there. Is that okay? Can you hear me now?

CATHY PARKES: Yes.

PAMELA BENDELL: Okay. My name is Pamela Bendell. My mother, June Bendell, passed away on May 8th of this year. My parents were in

Ottawa, which is a retirement section, 2007 and 2008.

My mother was evicted because she ran away. We put her in another long-term care facility in Scarborough.

My dad passed away there, and I brought my mom back to Orchard Villa in July 2009. So she's been there a long time.

The adulate, I used to work in the facility in the '80s. I understand the operation of a private versus public facility. My mother had a horrific time. She was nonverbal. To go through that many years, 11 years, you would be here for the rest of the night.

I will bring it up close to the pandemic. If you remember the military report of a woman being fed or a resident being fed lying down and aspirated, that was my mother.

My mother shouldn't have been lying down. My mother was nonverbal. My mother could not feed herself. Hasn't been able to for about four years.

I have no idea what happened to her after March 8th, was my last visit with her. I do have a resident inside that would send me videos

and update me on what was going on.

My mother lost a considerable amount of weight, but yet the nursing home would tell me that she was eating at 75 percent capacity. I said "she would eat at 100 percent if she's fed, so where did you get your 75 percent capacity?"

My mother had black eyes. I was in with Beverley and Jason just before COVID because they dropped the patient lifter on my mother's knee and smashed her knee.

My mother had UTI infections. You talk about annual reports with the family. We would hear that my mother was getting a shower one night and a bath another night.

Someone had changed her reporting. She had not been in a tub or a shower for four years.

MARIE TRIPP: Oh!

PAMELA BENDELL: My mother had a broken toe -- because when she was in a recliner -- because she was rigid -- she had Lewy body dementia and Parkinson's.

Because she was rigid, when they turned a corner, they broke her toe against a door frame.

Also, she had -- I said about her black eyes; she had a broken toe; she had a shattered

knee.

When you talk about top down, yes, I heard someone was going to be disciplined. They just played one against the other.

And I happen to know one of the PSWs because I used to work with her years ago, and she was fabulous.

We had hired someone for eight years to go into the facility three times a week to ensure, when I was working or away, that my mom was being fed.

There was one other thing that -- oh, well, there's so many things. But at the end, when my mother died, I was on the phone when she was dying because she was choking.

And I had the doctor on one phone. I had my brother on my cellphone, and he was narrating it through.

And I was asking "could I come? Is she going to go to the hospital?"

The coroner reached out to me and put my mother's death was accidental. I since found out he's changed the report to say that she died of COVID. My mother didn't have COVID. So there's an investigation into that. It's been lie after lie

after lie after lie.

And, Cathy, when you said about the effect on us, it's unimaginable. Night after night, I think about my mother lying in a bed, can't speak, can't eat, can't do anything.

And I was getting emails saying she was eating at 75 percent, 80 -- everything was fine. She was being bathed.

No. Terrible. So that's what I have to say.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, this is very helpful for us as, as was said. It helps us stay grounded. And we --

Yes, Cathy?

CATHY PARKES: Oh, sorry. I didn't mean to interrupt you. Go ahead.

COMMISSIONER FRANK MARROCCO (CHAIR): No, no. What were you going to say?

CATHY PARKES: Well, I was going to say this term of "they ate 75 percent of their meal," we need to encourage that to stop because if we're looking at half of the sandwich and "they've eaten 75 percent of it," that's not accurate to their nutritional needs daily.

And those terms don't work because that

is what was happening especially during April and May. There wasn't kitchen staff, and they were being served sandwiches. So eating 75 percent of the sandwich can't possibly be helping in the way that it should.

And I also want to speak to the point that I had a real problem myself with not only a lack of communication but then the communication that I was getting was absolutely false.

The day I saw my father before he died, he was comatose. I saw him through his window. I was told he was sitting up and eating 75 percent of his meal that day, and yet they couldn't get water into him to give him his medication.

So the charting wasn't being done. Old information was being given. My father's fever was much higher than they were reporting on April the 13th, two days before he passed away, but they didn't have accurate information.

They were holding off on swabbing and testing for COVID until a resident's temperature reached a certain level. That can't happen. That was awful. I had to demand that my father have a COVID test.

So what little information we were

getting was absolutely false, and that's really concerning.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, thank you very much for sharing this. We are, you know, accessible through the counsel and the people you've been dealing with.

You know, it's not as if, once this interview is over, there's no way of getting ahold of us or, you know, asking us or contacting us if you feel the need to or if there's something you're curious about.

But I want to thank you for coming, and I want to thank you for the organized way. I appreciate this last bit of conversation, which I generated with that question, but your submission was so orderly. It's very easy to follow, and we understand what recommendations you're making.

We will probably issue further reports. We're still working on that and what that will look like. We're still trying to decide, but we do have a bit of an idea of what we're going to do next.

And I want to thank you all again.

CATHY PARKES: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): And with that, I'll say good evening, and you know

where to find us. If you've got some information you think would be helpful, please --

PAMELA BENDELL: Can I just close by saying, sorry, I have photographs, if you'd like photographs. I would be willing to share them to you, if you'd like to see the proof I have.

COMMISSIONER FRANK MARROCCO (CHAIR): I think that would be helpful. I don't know if it was Ida or -- whoever you were dealing with that made the arrangements, that would be the best way to get them to us.

PAMELA BENDELL: Absolutely. But I just want you to know there's photographs available, and I'm sure I'm not the only family member that has --

COMMISSIONER FRANK MARROCCO (CHAIR): Well, you know, we're not prosecuting, but we will get into this a bit, I think. And that sort of thing can be quite helpful depending on what people tell us.

CATHY PARKES: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Good evening, everybody.

-- Adjourned at 4:56 p.m.

REPORTER'S CERTIFICATE

I, MCKAYA MCDONALD, CSR, Certified Shorthand Reporter, certify:

That the foregoing proceedings were taken before me at the time and place therein set forth;

That all remarks made at the time were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 25th day of October, 2020.

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This is Exhibit “F” referred to in
the Affidavit of NATALIE
MEHRA sworn before me this
18th day of April, 2024

A Commissioner for Taking Affidavits

GTA

Improper use of PPE. Medicine to the wrong patient. Injuries from falls. A look at the problems inside Orchard Villa as COVID-19 deaths climbed

As the pandemic raged on in May and June of this year, inspectors from the Ministry of Long-Term Care acting on a complaint found more than a dozen instances in which the home failed to comply with regulations.

Aug. 31, 2020

A woman tries to speak to her mother, through a window at Orchard Villa care home in Pickering on April 25.

By **Kenyon Wallace Investigative Reporter**

Orchard Villa, the Pickering long-term-care home with the most COVID-19 deaths in the province, continued to fail to comply with provincial legislation designed to protect residents – even after more than 70 residents died and military personnel were sent in to assist.

As the pandemic raged on in May and June of this year, inspectors from the Ministry of Long-Term Care acting on a complaint found more than a dozen instances in which the home failed to comply with regulations, including not ensuring staff received infection control training within one week of hire, failing to ensure a resident who had fallen received a proper skin assessment, and failing to stop staff from administering a drug to a resident that was not prescribed.

These findings are in addition to more than 120 citations of failure to comply with the Long-Term Care Homes Act and its regulations between July 2015 and December 2019 recently detailedby the Star.

Since the beginning of the pandemic, 206 residents of the 233-bed Orchard Villa have been infected with COVID-19. Seventy-one residents in the long-term-care home died, and another seven died in the adjacent retirement home. More than 100 staff members have tested positive for the virus. The Durham Region Health Department declared the COVID-19 outbreak at Orchard Villa over on June 11.

A piper marches off during a vigil for COVID-19 victims at the Orchard Villa long-term care home in Pickering, Ont. on Monday June 15, 2020.

THE CANADIAN PRESS/Frank Gunn

In an email to the Star, Jason Gay, executive director of Orchard Villa, said during the four weeks inspectors were at the home, they reviewed a wide range of operations and "found the home to be clean, with adequate PPE and other supplies."

"When inspectors identified an area of improvement, action was immediately taken and most were resolved before the inspectors left the home. This action included on-going education of staff on our Falls Prevention Policy and the Skin and Wound Care Policy," he said. "We are currently auditing to ensure compliance with these policies."

He added that the home's staff are "hardworking and compassionate people, and they always impress us with their dedication and willingness to learn."

Sharon Navarro, a spokesperson for Lakeridge Health, which has assumed temporary management of Orchard Villa long-term-care home on June 12 for 90 days at the behest of the provincial government, said work is "well underway" to stabilize the home's staffing and operations and to "help the facility develop the capacity to meet quality and safety standards."

In late April, when Durham Region's medical officer of health asked Lakeridge Health to lead the home's response to the outbreak, the home was "significantly understaffed," said Navarro, adding that at one point during the outbreak, Orchard Villa had only 20 per cent of its full staffing complement.

She said staffing levels have now been corrected and meet current standard ratios for long-term-care homes, and that all staff and leaders receive mandatory infection prevention and control training. There is also continuous auditing of

environmental cleaning, dietary compliance and hand hygiene, and PPE levels are audited daily to ensure a 30-day supply, Navarro said.
The citations for non-compliance stemming from the May and June inspections are detailed in a July 27 report and describe a wide range of problems touching on different aspects of resident care.

One notice of compliance failure issued by inspectors details the case of a resident sent to hospital after a fall. The inspection report says three staff members lifted the resident off the floor and into bed instead of using a “lifting device” as mandated by the home’s own falls prevention and management policy. In this case, inspectors asked the home to come up with a “voluntary plan of correction.”

Another notice describes a complaint made to the ministry of long-term care about a resident who suffered “multiple injuries” due to falls, one of which resulted in hospitalization. Inspectors reviewing the resident’s clinical notes found that staff did not perform a skin assessment using a “clinically appropriate instrument” on two occasions. They also found that the home failed to ensure that a member of registered nursing staff examined the resident’s skin.

The report also says that while in the home, an inspector witnessed a personal support worker (PSW) helping a resident with a drink while wearing just a cloth mask and goggles – even though a sign posted on the resident’s door directed staff to wear full personal protective equipment (PPE) including a mask, face shield, gown and gloves. The inspector interviewed the PSW, who said that they were aware of the requirements to don full PPE but used their own cloth mask due to sensitive skin to the surgical mask provided by the home.

June Morrison protests on behalf of her late dad, who died of COVID-19 while he was a resident at Orchard Villa in Pickering. Morrison is among 41 families calling for a criminal investigation into what occurred at the home.

Susie Kockerscheidt/Torstar

June Morrison, whose father George died on May 3 at the age of 95 after contracting COVID-19 at Orchard Villa, said she is “not surprised” to learn that the home was found to have further compliance failures.

“I personally think they need their licence revoked. They have proven time after time based on the inspection reports that they fail to live up to regulations and legislation,” Morrison said.

George Morrison was admitted to hospital with apparent anorexia, dehydration and a urinary tract infection before his death, his daughter said.

“I don’t think they’ve learned anything,” said Cathy Parkes, whose father Paul Parkes, an Orchard Villa resident, died on April 15 at age 86. It wasn’t until three weeks after her dad died that Parkes says she learned he had tested positive for COVID-19.

Both Parkes and Morrison have filed lawsuits against Orchard Villa and its owner. They are also among 41 families calling for a criminal investigation into what occurred at the home.

Ministry inspectors also found that Orchard Villa failed to ensure staff received training within one week of hire, as required by amendments to regulations under the Long-Term Care Homes Act made in March to deal with the pandemic. The changes to the regulation mandated that training on such areas as infection prevention and control, the residents' bill of rights and the home's policy on abuse and neglect of residents within one week.

Inspectors interviewed several personal support workers and registered practical nurses at Orchard Villa who "confirmed that they had no training" in the areas required by the regulation changes. Some said they had training on donning and doffing of PPE and hand hygiene. The ministry asked the home to write a voluntary plan of correction.

In another instance, inspectors reviewing a resident's clinical records that the resident was given a medication they were not prescribed.

"The licensee has failed to ensure that no drugs are administered to a resident in the home unless the drug has been prescribed for the resident," says the inspection report. It does not say what happened, if anything, to the resident.

"Clearly the oversight of that facility has been in my view negligent on the face of it because you see no director's orders issued, you see no licence revocations, you see no cease admissions. That speaks to oversight that is off the rails," said Patricia Spindel, former associate dean of health sciences at Humber College and co-founder of Seniors For Social Action Ontario (SSAO), a group of social activists from across Ontario.

A director's order is issued by the director of performance improvement and compliance at the ministry of long-term care and can include revocations of licence, mandatory management orders and return of funding orders, among other things.

"When you have homes in this kind of trouble and for this period of time and there's been no licence revocation, that just makes no sense to me," added Spindel.

Gillian Slogget, a spokesperson for Minister of Long-Term Care Merrilee Fullerton, said the government and its health partners "continue to work around the clock to safeguard the residents and staff at the home." She said repeated non-compliance is of "serious concern" and can result in "escalated measures and sanctions by the ministry."

"Long-term care is a huge priority for our government and every option is on the table to make it better. We are forging ahead with the critical work we had underway before this pandemic hit, and will leave no stone unturned as we

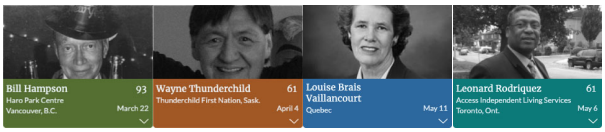
undertake badly needed system transformation," Slogget said.
Laura Tamblyn Watts, CEO of CanAge, a national seniors' advocacy group, says the province must address the conditions we are asking our seniors to live in and that includes looking at what incentives long-term-care home owners have to respond to compliance failures.

"We know that when there's consistent failure to comply and where outcomes are dangerous to residents, that there needs to be not just appropriate support but appropriate response, which means there needs to be teeth in the inspections and legislation," she said.

"What we've seen with COIVD is not so much a surprise but just an illumination of the problems in the system that we always knew were there. The question is: will we now actually fix it?"

The lives they lived

Have you lost a loved one to COVID-19? Email us at covidremembrance@thestar.ca to add their story to our book of remembrance.



Kenyon Wallace *is a Toronto-based health reporter for the Star. Follow him on Twitter:* **@KenyonWallace** *or reach him via email:* ***kwallace@thestar.ca****.*

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This is Exhibit “G” referred to in
the Affidavit of NATALIE
MEHRA sworn before me this
18th day of April, 2024

A Commissioner for Taking Affidavits

https://www.durhamregion.com/news/it-s-our-worst-nightmare-report-details-horrendous-conditions-at-pickerings-orchard-villa-retirement-residence/article_66279b1a-7a3d-569b-824c-e65e2d737965.html

NEWS

‘It’s our worst nightmare:’ Report details horrendous conditions at Pickering’s Orchard Villa Retirement Residence

Daughter of Orchard Villa victim wants public inquiry after Canadian Armed Forces releases report documenting what they found at the long-term care facility

PICKERING News Advertiser.

By **Kristen Calis** Pickering News Advertiser

Flowers have been placed at the entrance of Pickering's Orchard Villa Retirement Community. May 6, 2020 - Jason Liebregts/Torstar

PICKERING — Cockroaches and flies, residents choking from improper feeding, the stench of rotten food, and patients left in soiled diapers at Orchard Villa in Pickering were some of the findings detailed in a report by the Canadian Armed Forces.

The military began assisting at the long-term care facility in late April, along with four other homes, all of which were hit hard by the COVID-19 pandemic. The military was also deployed to Altamont Care Community in Toronto, Eatonville Care Centre in Toronto, Hawthorne Place in Toronto and Holland Christian Homes' Grace Manor in Brampton.

A report dated May 14 by the CAF was released on Tuesday.

"It was the worst report, the most heart-wrenching report I have ever read in my entire life. Ever," said Ontario Premier Doug Ford during a news conference Tuesday.

An Orchard Villa representative could not be reached for comment.

The report alleges improper feeding appears to have contributed to one death at Orchard Villa. This was due to a lack of proper positioning as residents were being fed at the long-term care home. The report stated: "PSWs and nurses aren't always sitting up residents before feeding/hydrating/giving meds; choking/aspiration risk is therefore high …" In this particular case, the report said a resident started choking when they were being fed while laying on their back. Staff was unable to dislodge the food or revive the resident.

"This has confirmed what we know, but it told us more than what we knew," said June Morrison, whose father lived at the home before he died on May 3.

George Morrison had received a false negative test result for COVID-19 twice. When he was later admitted to hospital, June Morrison was told her dad, always a good eater, had anorexia. She awaits the results of an autopsy.

"It's confirmed everything we know and it's our worst nightmare," she said of the report.

The CAF noted a rotten food smell was coming from inside a patient's room. The CAF member found a stack of old food trays inside a bedside table.

The report also listed inappropriate personal protective equipment was used throughout all staffing levels, including doctors.

It noted “mouth care and hydration schedules not being adhered to.”

The report said nurses appeared “to document assessments without having actually assessed the patient.”

It noted: “Staff putting food and important belongings outside of residents reach.”

The report noted an incident of a likely fractured hip that was not addressed by staff.

It found: “Respecting dignity of patients not always a priority. Caregiver burnout noted among staff.”

There were several issues listed in regards to staffing and communication.

The report found liquid oxygen generators were not filled, therefore unusable; patients were sleeping on bare mattresses; and there were multiple falls after which the residents weren't assessed.

In order to keep residents from wandering the halls, their walking aids were removed and their mattresses put on the floor because they couldn't get up from that low of a position, the CAF said.

The province has begun an active investigation based on the report. One death has been referred to the Office of the Chief Coroner for investigation. In addition to continued regular inspections, the Ministry of Long-Term Care inspections branch will immediately investigate specific critical incidents referred to in the report.

The government also recently announced it will launch an independent commission into Ontario's long-term care system beginning in September.

"We have said for a long time that our long-term care system needs to be repaired and advanced and we will do just that for our loved ones," Ford said.

Morrison wants a public inquiry.

“We all want a public inquiry,” she said. “We all want it now, not later.”

RELATED STORIES

'COVID body:' Woman details father's death from coronavirus at Pickering's Orchard Villa

'Disturbing' news of possible privacy breach at Orchard Villa in Pickering

Military report details long-term care issues

'My duty to my mother': Class-action lawsuit filed against Orchard Villa

'We're taking over:' Province now in charge of Pickering's Orchard Villa long-term care home

She said the Minister of Long-Term Care Merrilee Fullerton should call for the inquiry before breaking for the summer next week.

“They have a chance to do something right before they walk out of the legislative room next week.

“Step up before you step away,” was her message to Fullerton.

A statement by Lakeridge Health following the report’s release said Orchard Villa had been managing the outbreak for almost two weeks before a team from Lakeridge Health was brought in to support them.

“Lakeridge Health took immediate actions to begin to manage the outbreak at Orchard Villa when it arrived on site in late April,” it said. “These included adding dozens of front-line providers to support care to residents along with initiating decontamination (deep cleaning), infection prevention and control measures and ongoing staff education and training on the use of PPE.”

On the day the report was released, 77 deaths at Orchard Villa had been reported.

The province said the number of new cases is decreasing and there are a number of recovered cases at the home.

KC

Kristen Calis *is a reporter with durhamregion.com. She can be reached at* ***kcalis@durhamregion.com.***

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JOURNALISTIC STANDARDS

ABOUT US

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MEHRA sworn before me this
18th day of April, 2024

A Commissioner for Taking Affidavits

Home Report

The LTC home listed on this screen is the result of your search. To view details on this home:

- Click on the corresponding tabs to view the Home Profile or Inspections for a LTC home.

ORCHARD VILLA
1955 Valley Farm Road
Pickering, L1V3R6
Tel : (905) 831-2522
Fax : (905) 420-6030
Click here to visit this LTC home's website

1. Home Profile
2. Inspection(s)

Local Health Integration Network (LHIN)
Central East
Home, Community and Residential Care
Central East
Home Administrator
Gethro Dorval
Licensee
Cvh (No. 6) Lp By Its General Partners, Southbridge Health Care Gp Inc. And Southbridge Care Homes (A Limited Partnership, By Its General Partner, Southbridge Care Homes Inc.)
Management Firm
Cvh (No. 6) Lp By Its General Partners, Southbridge Health Care Gp Inc. And Southbridge Care Homes (A Limited Partnership, By Its General Partner, Southbridge Care Homes Inc.)
Home Type
For-Profit
Licensed Beds
Home with approximately 233 beds
Approved Short Stay Beds
No
Residents' Council
Yes
Family Council

Yes
Accreditation
Yes
Home Designated Under French Language Services Act
No
Additional Information

Terms and Definitions

Additional Information
Information in addition is added here such as the operation of a French language unit within an English services LTC home.

Approved Short-Stay Beds
Short-stay beds are a response to the community's need for 'respite' and 'supportive care' programs. An individual is admitted into a long-term care (LTC) home for a specific short time period. The respite program provides relief to the individual's caregiver. The supportive care program allows an individual to recover strength, endurance or functioning. LTC home operators have the opportunity to apply to the Ministry of Health and Long-Term Care (MOHLTC) to operate short-stay beds within their existing licensed or approved beds, and the MOHLTC approves the beds based on need and suitability of rooms offered. Persons in the respite program usually stay for up to 60 days and those in the supportive care program usually stay for up to 90 days. A person can stay a maximum of 90 days in a short-stay program within a year. Eligibility for admission and placement in short-stay beds are determined by the Home, Community and Residential Care.

Accreditation
Accreditation is a voluntary process that LTC homes may use to assess their services and help them improve the quality, safety and efficiency of their performance for the benefit of their residents and the health system.

The process of Accreditation encourages an organization to:

- Assess services and determine where to focus improvement efforts
- Develop standardized processes to improve efficiency
- Mitigate risk and support the uptake of best practices
- Build a culture of quality, safety and excellence
- Publicly promote their commitment to offering safe, high-quality services.

Long-term care (LTC) homes apply for accreditation to Accreditation Canada or the Commission on Accreditation of Rehabilitation Facilities (CARF). Details for each organization, as well as the method for achieving accreditation may be found at the following websites:

- Accreditation Canada: http://www.accreditation.ca/
- Commission on Accreditation of Rehabilitation Facilities: http://www.carf.org/home/

Home, Community and Residential Care
Home, Community and Residential Care providers are the local organizations established by the Ministry of Health and Long-Term Care that provide access to government-funded home and community services, including admission into LTC homes. Home, Community and Residential Care have Case Managers/Placement Coordinators who authorize admissions into LTC homes (for both permanent and short-stay admissions) and arrange for home care services. There is an application process that must be completed for placement into a LTC home. For more information about Home, Community and Residential Care in your area, see the Home, Community and Residential Care section.

Family Council
An autonomous (self-led and self-determining) group made up of families and friends of the residents of a LTC

home that meets on a regular basis with an emphasis on mutual support and advocacy. This group provides a voice in decisions that affect their loved ones and strives to develop a better understanding between families and the management and staff of a home.

Home Administrator
The Administrator has overall responsibility for the day-to-day operations of a home.

Homes Designated Under French Language Services Act
Some LTC homes are designated under the French Language Services Act. This means that French-speaking residents are guaranteed services and care by members of the staff who speak French.

Licensee
Is the holder of a licence issued by the Ministry of Health and Long-Term Care, and includes an individual or corporation, the municipality or municipalities or board of management that maintains a municipal home, joint home or First Nations home approved the ministry.

Licensed Beds
The number of beds that are licensed by the ministry in the LTC home.

Local Health Integration Network (LHIN)
LHINs are not-for-profit corporations that are responsible for planning, integrating and funding local health services in 14 different geographic areas of the province. LHINs are based on a principle that community-based care is best planned, coordinated and funded in an integrated manner within the local community because local people are best able to determine their health service needs and priorities. LHINs are intended to be the managers for health services that are delivered in hospitals, long-term care homes, community health centres, community support services and mental health agencies. For more information about LHINs, see the Local Health Integration Network (LHIN) section.

Management Firm
Some LTC home operators may use a management firm to manage the day-to-day operations of the home. The name of a management firm will only appear in the Home Profile section on this website where the home operator has made such an arrangement. The management firm is different than other companies that may provide services in the home such as maintenance and food services.

Home Type
There are various types of operators of LTC homes: charitable organizations, municipalities, corporations, partnerships and sole proprietors. The Ministry of Health and Long-Term Care funds LTC homes to provide care and services to their residents. Nursing homes may be either for-profit or non- profit. Charitable and municipal homes are non- profit. Some hospitals in northern communities may also operate LTC beds under the Elderly Capital Assistance program.

Residents' Council
A Residents' Council is an independent, self-determining group made up of residents in a home. All residents are entitled to be members. The group, perhaps with an elected Executive, meets regularly to receive and discuss residents' concerns, to plan activities, and to have a voice in the decisions and routines that affect residents' daily lives. When a Residents' Council does not exist in a home, the Administrator of the home must inform all residents annually of their right to form such a council. If any three (3) residents wish to have one, the Administrator must assist with the establishment of the group and support it.
For More Information

- Frequently Asked Questions
- Glossary of terms used on this site
- Contact a Home, Community and Residential Care
- Checklist to use when visiting a home
- How to apply to a LTC Home

For More Information

Call **ServiceOntario**, Infoline at 1-866-532-3161
TTY 1-800-387-5559
In Toronto, TTY 416-327-4282
Hours of operation : 8:30am - 5:00pm

To find a Long-Term Care Home which offers English or French Language Services, please contact your local Home, Community and Residential Care at 310-2222.

The Ministry of Long-Term Care is committed to accommodating users who may have special accessibility requirements. If you require such accommodations, please contact AskHealthData@ontario.ca.

To register a complaint about a home, contact the LTC Action Line at:
Long-Term Care ACTION Line
1-866-434-0144
TTY 1-800-387-5559
7 days a week, 8:30am to 7:00pm, EST

Home Report

The LTC home listed on this screen is the result of your search. To view details on this home:

- Click on the corresponding tabs to view the Home Profile or Inspections for a LTC home.

ORCHARD VILLA
1955 Valley Farm Road
Pickering, L1V3R6
Tel : (905) 831-2522
Fax : (905) 420-6030
Click here to visit this LTC home's website

1. Home Profile
2. Inspection(s)

Year 2024
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Jan 18, 2024
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Aug 17, 2023

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Complaints Inspection with Order(s) of the Inspector
Apr 11, 2011
Complaints Inspection with Order(s) of the Inspector Apr 11, 2011 - PDF
(657 KB)
Year 2010
Inspection Type
Inspection Report
Date
Document
Complaints Inspection
Dec 20, 2010
Complaints Inspection Dec 20, 2010 - PDF
(134 KB)
Complaints Inspection
Dec 09, 2010
Complaints Inspection Dec 09, 2010 - PDF
(410 KB)
Complaints Inspection
Nov 09, 2010
Complaints Inspection Nov 09, 2010 - PDF
(131 KB)
Critical Incident Inspection
Nov 09, 2010
Critical Incident Inspection Nov 09, 2010 - PDF
(121 KB)
Critical Incident Inspection
Jul 15, 2010
Critical Incident Inspection Jul 15, 2010 - PDF
(219 KB)

How to interpret these results

This page displays the inspection reports that have been issued for the Long-Term Care home (LTCH) you selected.

Terms and Definitions

Licensee
The operator of a LTCH.

Inspections
Ministry of Long-Term Care (MLTC) inspectors conduct inspections at every LTCH at least once a year to determine compliance with the *Fixing Long Term Care Act, 2021* (FLTCA) and Ontario Regulation 246/22 (Regulation).

Inspection Report
A summary of an inspection, including any findings of non-compliance, written by a LTCH Inspector.

Inspection Type
The ministry conducts unannounced inspections focusing on complaints, critical incidents, follow-ups, proactive compliance, and post-occupancy.

Complaint, Critical Incident and Follow-Up Inspections

- LTCH inspectors visit long-term care homes to inspect on:
  - complaints received by a resident, family member, staff member or the public;
  - critical incidents that were reported by the LTCH;
  - follow-ups to a previously issued Compliance Order to ensure that the home has corrected the non-compliance.

Proactive Compliance Inspections

- LTCH inspectors conduct proactive inspections using a standardized approach to identify any non-compliance with FLTCA and the Regulation. These inspections are a stand alone inspection and do not cover complaints, critical incidents, follow ups or post-occupancy, unless it is necessary.
- Proactive Compliance Inspections were referred to as Resident Quality Inspections prior to 2019.

Post-Occupancy Inspections

- LTCH inspectors conduct post-occupancy inspections after a newly built or redeveloped LTCH to ensure compliance with FLTCA and the Regulation. These inspections are usually conducted within two weeks after the last resident has moved in the LTCH.

Intake
Intakes are a record of the initial Complaint or Critical Incident that was received.

Inspection Protocols

- Audit tools that may be used to inspect an issue in-depth and helps determine if a home is compliant with FLTCA and the Regulation.

Inspection Results
If a LTCH Inspector finds any non-compliance with FLTCA or the Regulation, a non-compliance action is issued under the Inspection Results section of the report, such as:

Non-Compliance Remedied

- A low-risk instance of non-compliance that did not cause any harm or risk of harm to residents. Non-Compliance Remedied are issued when the non-compliance was rectified by the LTCH and verified by a LTCH Inspector during the inspection.

Written Notification

- Issued for non-compliances with a low impact or risk to residents.

Compliance Order

- Issued when a Licensee has failed to comply with a requirement under FLTCA or the Regulation. Compliance Orders are:
  - Usually issued for non-compliances with a moderate to significant impact or risk to a resident's health, safety, or quality of life.
  - Usually require certain action(s) the LTCH has to take in order to become compliant, e.g., developing a plan or training for staff
  - Always require a follow-up inspection.

Administrative Monetary Penalty

- Issued when an LTCH:
  - Has not complied with a Compliance Order
  - Receives a Compliance Order and has had at least one other Compliance Order; for the same requirement within a three-year period; and
  - Receives a Compliance Order related to air conditioning requirements.

Re-Inspection Fee

- Issued when an LTCH is still non-compliant with a Compliance Order after a follow-up inspection.

Director Referral

- When a LTCH Inspector refers a non-compliance to the Director for review.

Inspection Report Date
The date the LTCH Inspection Report was finalized by the Inspector.

Notification of Cease of Admissions
A directive from the Director to Home and Community Care Support Services to cease authorizing admissions to the LTCH for a specific period of time.

Lifting of Cease of Admissions
A directive from the Director to Home and Community Care Support Services to resume authorizing admissions to the LTCH for a specific period of time.
For More Information

- Frequently Asked Questions
- Glossary of terms used on this site
- Contact a Home, Community and Residential Care
- Checklist to use when visiting a home
- How to apply to a LTC Home

For More Information

Call **ServiceOntario**, Infoline at 1-866-532-3161
TTY 1-800-387-5559

In Toronto, TTY 416-327-4282
Hours of operation : 8:30am - 5:00pm

To find a Long-Term Care Home which offers English or French Language Services, please contact your local Home, Community and Residential Care at 310-2222.

The Ministry of Long-Term Care is committed to accommodating users who may have special accessibility requirements. If you require such accommodations, please contact AskHealthData@ontario.ca.

To register a complaint about a home, contact the LTC Action Line at:
Long-Term Care ACTION Line
1-866-434-0144
TTY 1-800-387-5559
7 days a week, 8:30am to 7:00pm, EST

Ontario

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

apport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St., 4th Floor
Ottawa ON K1S 3J4

Telephone: 613-569-5602
Facsimilie: 613-569-9670

Bureau régional de services de Ottawa
347, rue Preston, 4iém étage
Ottawa ON K1S 3J4

Téléphone: 613-569-5602
Télécopieur: 613-569-9670

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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'insptection
July 15, 2010	2010_103_2693_14Jul 221319	Other (Criticial Incident) CIS# 2693-000048-10 Log # O-000190

Licensee/Titulaire

Community Lifecare Inc., 1955 Valley Farm Road., 3rd floor, Pickering, ON L1V 1X6 Fax#- 905-831-1802

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

Community Nursing Home (Pickering), 1955 Valley Farm Road, Pickering, ON L1V 1X6

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

Darlene Murphy (ID#103)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an Other (Critical Incident) inspection related to resident injury as a result of an unsafe transfer.

During the course of the inspection, the inspector spoke with: Registered Practical Nurses, Personal Support Workers and the Director of Care

During the course of the inspection, the inspector did a walkthrough of the unit to observe the environment and resident care, and reviewed one resident record.

The following Inspection Protocols were used in part or in whole during this inspection:

- Safe and Secure Home Inspection Protocol
- Falls Prevention Inspection Protocol
- Personal Support Services Inspection Protocol

Findings of Non-Compliance were found during this inspection. The following action was taken:

1 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activitiés

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with Long Term Care Homes Program Manual Standards and Criteria.

B3.61: When transferring or positioning a resident, staff shall use safe transferring and positioning techniques and equipment.

Findings:

1. **A resident was transferred on June 23, 2010 with one personal support worker using a mechanical lift. This transfer technique is not supported by the resident plan of care or the home's policy.**

It is noted the home has already taken action on this matter by providing staff with re-education on safe lifts and transfers.

Inspector ID #:	103

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Oct 4/10 Darlene Murphy (#103)
Title: Date:	Date of Report (if different from date(s) of inspection).

Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
November 9, 2010	2010_111_2693_23Nov120305	CIS (Log # O-001538)

Licensee/Titulaire
Community Lifecare Inc.,
1955 Valley Farm Road, 3rd Floor,
Pickering, ON L1V 1X6
Fax: 905-831-1802

Long-Term Care Home/Foyer de soins de longue durée
Community Nursing Home-Pickering,
1955 Valley Farm Road,
Pickering, ON L1V 3R6
Fax: 905-420-6030

Name of Inspector(s)/Nom de l'inspecteur(s)
Lynda Brown, ID #111

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to a deceased resident.
During the course of the inspection, the inspector spoke with the Administrator, Director of Care, Registered Nurse on L unit, Registered Practical Nurse on L unit, Personal Support Workers on L unit.
During the course of the inspection, the inspector reviewed the resident's health record.

The following Inspection Protocols were used during this inspection: falls Prevention

☒ There are no findings of Non-Compliance as a result of this inspection.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: Date:	Date of Report: (if different from date(s) of inspection). Nov. 24/10

Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
November 9, 2010	2010_111_2693_24Nov120439	Complaint (Log # O-002242 & O-002485)

Licensee/Titulaire
Community Lifecare Inc.,
1955 Valley Farm Road, 3rd Floor,
Pickering, ON L1V 1X6
Fax: 905-831-1802

Long-Term Care Home/Foyer de soins de longue durée
Community Nursing Home-Pickering,
1955 Valley Farm Road,
Pickering, ON L1V 3R6
Fax: 905-420-6030

Name of Inspector(s)/Nom de l'inspecteur(s)
Lynda Brown, ID #111

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to a deceased resident.

During the course of the inspection, the inspector spoke with the Administrator and the Director of Care.

During the course of the inspection, the inspector reviewed the resident's health record.

The following Inspection Protocols were used during this inspection: Prevention of Abuse, Neglect and Retaliation

Based on new information received, the report has been amended December 22, 2010.

No Findings of Non-Compliance were found during this inspection.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Lynda Brown
Title: Date:	Date of Report: (if different from date(s) of inspection). January 7, 2011

Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
December 9, 2010	2010_148_2693_06Dec121654	Complaint Log #O-002326

Licensee/Titulaire
Community Lifecare Inc., 1955 Valley Farm Road, 3rd Floor Pickering, Ontario L1V 1X6
Fax 905-831-1802

Long-Term Care Home/Foyer de soins de longue durée
Community Nursing Home –Pickering, 1955 Valley Farm Road Pickering Ontario L1V 3R6
Fax 905 420 6030

Name of Inspector(s)/Nom de l'inspecteur(s)
Amanda Nixon, ID#148

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to the care and services provided to an identified resident.

During the course of the inspection, the inspector spoke with the Administrator, both Assistant Directors of Care, Registered Care Associate Manager, Registered Dietitian, Registered Practical Nurse, Personal Support Workers and the resident.

During the course of the inspection, the inspector reviewed the identified resident's health record including plan of care, physician orders, Medication Administration Records, flow sheets and the policy titled "Hypoglycemia Protocol".

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

Findings of Non-Compliance were found during this inspection. The following action was taken:

1 WN
1 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O 2007, c.8, s. 6

(c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. The plan of care for an identified resident does not reflect his/her needs related to abnormal blood glucose levels.
2. As ordered by the physician, the resident's capillary blood glucose is measured four times daily. The document titled "Glucose Monitoring Record" indicates that between the dates of November 23, 2010 and December 1, 2010, the resident had four blood glucose readings below 4.0mmol/L.
3. On December 9, 2010, interview with Anne-Christin, Registered Practical Nurse responsible for the resident's care, stated that the resident does not exhibit any symptoms when blood glucose levels are abnormal.
4. The plan of care, printed December 9, 2010 for the resident indicates that registered staff are to monitor him/her for symptoms of hyperglycemia and hypoglycemia; there is no indication in the plan of care that the resident is asymptomatic to abnormal blood glucose levels.

Inspector ID #:	148

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 plan of care for the resident reflects the his/her care needs in respect to monitoring hyperglycemia and hypoglycemia, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Amanda Nixon
Title: Date:	**Date of Report:** (if different from date(s) of inspection). December 22, 2010

Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
December 20 2010	2010_166_2693_30Dec133921	Log #O-002540

Licensee/Titulaire
Community Lifecare Inc.
1955 Valley Farm Road
Pickering ,ON. Fax 905-831-1802
L1R 3VR

Long-Term Care Home/Foyer de soins de longue durée
Community Nursing Home Pickering
1955 Valley Farm Road
Pickering,ON Fax 905-420-6030
L1V 3VR

Name of Inspector(s)/Nom de l'inspecteur(s)
Caroline Tompkins #166

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related resident care.
During the course of the inspection, the inspector spoke with the resident, the Director of Care, the Social Worker, a PSW and a member of the Registered Nursing staff.
During the course of the inspection, the inspector reviewed the resident's clinical records and observed the resident.

There are no findings of Non-Compliance as a result of this inspection.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: Date:	Date of Report: (if different from date(s) of inspection). January 28 2011

Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
April 11, 2011	2011_021505_0001	Complaint and CIS (log # O-000706 & O-000719)

Licensee/Titulaire
Community Lifecare Inc.
1955 Valley Farm Road, 3rd Floor
Pickering, ON
L1V 1X6

Long-Term Care Home/Foyer de soins de longue durée
Community Nursing Home Pickering,
1955 Valley Farm Road,
Pickering, ON
L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur(s)
Lynda Brown (#111)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint and CIS inspection for a deceased resident.
During the course of the inspection, the inspector(s) spoke with: The Clinical Director of Care.
During the course of the inspection, the inspector(s): reviewed the resident's health record and the homes staff interviews.
The following Inspection Protocols were used in part or in whole during this inspection: Critical Incident and Complaints.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
2 CO: CO # 001, 002

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8,
s.6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
s.6(10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the residents care needs change or care set out in the plan is no longer necessary; or
care set out in the plan has not been effective

Findings:
An identified resident had a change in condition resulting in injury and the plan of care was not reviewed or revised.
An identified resident had a change in condition resulting in injury and did not receive the care set out in the plan of care based on the preferences of that resident.

Inspector ID #:	111

Additional Required Actions:
CO # 001 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #2: LTCHA, 2007 S.O. 2007, c.8, s.23(1) Every licensee of a long-term care home shall ensure that,
(a)every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i)abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulation.

Findings:
An identified resident sustained an injury of unknown cause and was not investigated immediately.

Inspector ID #:	111

Additional Required Actions:
CO # 002 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #3: O.Reg. 79/10, 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): 4. An injury in respect of which a person is taken to hospital (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required b the Director, make a report in writing to the Director setting out the following with respect to the incident:
Findings: An identified resident sustained an injury resulting in transfer to hospital and the Ministry was not notified within one business day after the occurrence of the incident and a report was not received by the Ministry within 10 days.

Inspector ID #:	111

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Lynda Brown
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). Apr. 26, 2011

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

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Name of Inspector:	Lynda Brown	**Inspector ID #**	111
Log #:	O-000706 & O-000719		
Inspection Report #:	2011_021505_0001		
Type of Inspection:	Complaint & Critical Incident		
Date of Inspection:	April 11, 2011		
Licensee:	Community Lifecare Inc. 1955 Valley Farm Road, 3rd Floor Pickering, ON L1V 1X6		
LTC Home:	Community Nursing Home Pickering, 1955 Valley Farm Road, Pickering, ON L1V 3R6		
Name of Administrator:	Metzie Lacroix (Acting)		

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

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)
Pursuant to: LTCHA, 2007 S.O. 2007, c.8, s.6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. s.6(10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (a) a goal in the plan is met; (b) the residents care needs change or care set out in the plan is no longer necessary; or (c) care set out in the plan has not been effective			
Order: The licensee shall ensure that when a residents care needs change, they receive the care as set out in the plan of care and based on the residents assessed needs. When the care set out in the plan of care is no longer necessary or has not been effective, that the resident is reassessed and the plan is reviewed and revised.			

Grounds: An identified resident had a change in condition resulting in injury and the plan of care was not reviewed or revised.	
This order must be complied with by:	Immediate

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)
Pursuant to: LTCHA, 2007 S.O. 2007, c.8, s.23(1) Every licensee of a long-term care home shall ensure that, (a)every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i)abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulation.			
Order: The licensee shall ensure that every alleged, suspected or witnessed incident of a resident resulting in injury of unknown cause is investigated immediately.			
Grounds: An identified resident sustained an injury of unknown cause and was not investigated immediately.			
This order must be complied with by:	Immediate.		

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 service for the Licensee.

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

Director
c/o Appeals Clerk

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 26 day of April , 2010.	
Signature of Inspector:	Lynda Brown
Name of Inspector:	Lynda Brown (#111)
Service Area Office:	Ottawa Service Area Office

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
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Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 26, Jun 20, 2011	2011_043157_0005	Critical Incident Log # O-000860

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

PATRICIA POWERS (157)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the home's Administrator and the home's Clinical DOC.

During the course of the inspection, the inspector(s) reviewed the resident's clinical health record, the home's incident investigation records, the home policies and procedures related to falls management, safe lifts and transfers and resident rights and the home's employee in service education records.

The following Inspection Protocols were used in part or in whole during this inspection:

Critical Incident Response

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

There are no findings of Non-Compliance as a result of this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Ontario

Ministry of Health and Long-Term Care

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

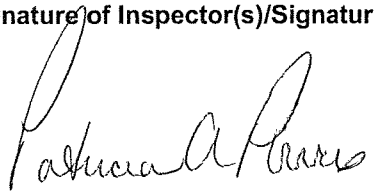
Ministére de la Santé et des Soins de longue durée

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

Definitions	Définitions
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.

Issued on this 20th day of June, 2011

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



Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 26, 27, 30, 2011	2011_043157_0004	Follow up

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

PATRICIA POWERS (157)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Clinical Director of Care, the charge RN.

During the course of the inspection, the inspector(s) reviewed the clinical health records of identified residents, observed the home's care units and staff interactions with residents.

The following Inspection Protocols were used in part or in whole during this inspection:

Critical Incident Response

Personal Support Services

There are no findings of Non-Compliance as a result of this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Ontario

Ministry of Health and Long-Term Care

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

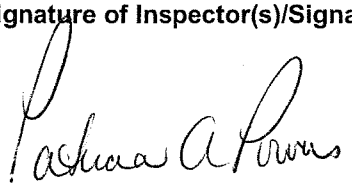
Ministére de la Santé et des Soins de longue durée

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

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.

Issued on this 31st day of May, 2011

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



Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Téléphone: 613-569-5602
1-877-779-5559
Télécopieur: 613-569-9670

Date(s) of inspection/Date de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 26, 2011	2011_043157_0004	Follow Up

Licensee/Titulaire de permis
Community Lifecare Inc., 1955 Valley Farm Road, Pickering, ON L1V 3R6

Long-Term Care Home/Foyer de soins de longue durée
Community Nursing Home Pickering, 1955 Valley Farm Road, Pickering, ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs
Pat Powers, #157, Caroline Tompkins, #166

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ORDER #/ GENRE DE MESURE/ORDRE NO	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007, S.O. 2007 c. 8, s.6(7)	CO 001	2011_021505_0001	#111
LTCHA, 2007, S.O. 2007 c. 8, s.23(1)	CO 002	2011_021505_0001	#111

Issued on this 31 day of May, 2011

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 6, 7, 8, 9, 12, 13, 14, 18, 2011	2011_041103_0025	Complaint

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with residents, Personal support workers, Registered Practical Nurses, Registered Nurses, Environmental Services Manager, Handy Person, Dietitian, Director of Care and the Administrator.

During the course of the inspection, the inspector(s) made observations during a walk through of Linden, Birch, Maple and Pine units, observed resident dining, observed resident care, and reviewed resident health records. The inspector completed five complaint inspections during the inspection period.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

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

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

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. Resident dining was observed during two meal services. Staff were noted to be providing assistance to more than two residents who required total assistance with eating and drinking.
(s. 73. (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 no person simultaneously assists more than two residents who need total assistance with eating or drinking, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following subsections:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items;
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and
(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. On a walk through, linens were found to be in disrepair. s. 89 (1) (c)
2. Linen cupboard and storage areas were observed and shortages of linen were identified. s. 89 (1) (b)

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Routine foot care services are available in the home. A chiropodist and a podiatrist are available by referral as required for foot care needs beyond the scope of the foot care nurse.
2. A resident's foot care records were reviewed. The foot care nurse documented the resident's toenails required trimming by a person specialized in foot care.
The resident developed complications related to foot care. There were no referrals made for a chiropodist, a podiatrist or a specialist in the area of foot care to assess this resident.

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

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. A resident's plan of care was reviewed. The resident was not provided with the care as outlined in the plan of care.

Issued on this 18th day of September, 2011

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 7, 13, 20, 21, Oct 4, 11, 12, 13, 2011	2011_041103_0026	Critical Incident

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Registered Practical Nurses, Registered Nurses, Personal Support workers, the Dietitian, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed resident health care records and observed resident care. Findings from the following log numbers were utilized to prepare this report: log #O-0017-50-11, log # O-002054-11, O-001955-11, log# O-000386-11.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Specifically failed to comply with the following subsections:

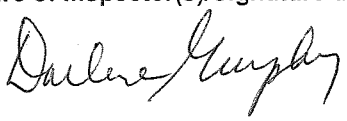
s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in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

Findings/Faits saillants :

1. The licensee failed to follow the Dietary policy for an identified resident.
Log # O-001750-11

Issued on this 20th day of October, 2011

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



Ontario

Ministry of Health and Long-Term Care

Ministére 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2011_041103_0026
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Sep 7, 13, 20, 21, Oct 4, 11, 12, 13, 2011
Licensee / Titulaire de permis :	COMMUNITY LIFECARE INC 1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6
LTC Home / Foyer de SLD :	COMMUNITY NURSING HOME (PICKERING) 1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~MIKE MACDONALD~~ Metzi Lacroix

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

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with s. 19 to ensure actions are taken to protect residents from abuse or neglect. The plan shall include staff training to ensure policies and procedures are followed in particular, resident abuse and neglect and resident responsive behaviors.

This plan must be submitted in writing to Inspector, Darlene Murphy at 347 Preston St., Ottawa, ON K1S 3J4 or by fax at 613-569-9670 on or before October 21, 2011.

Grounds / Motifs :

1. The licensee failed to protect an identified resident from neglect by failing to provide the resident with prescribed dietary nourishment. s. 19 (1)
Log # O-001750-11.

The licensee failed to protect an identified resident from physical abuse that resulted in an injury. s. 19 (1)
Log # O-002054-11

The licensee failed to protect an identified resident from emotional abuse. s. 19 (1)
Log # O-001955-11. (103)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 11, 2011

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

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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

Issued on this 13th day of October, 2011

Signature of Inspector / Signature de l'inspecteur : Darlene Murphy

Name of Inspector / Nom de l'inspecteur : DARLENE MURPHY

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 16, 19, 20, 21, 22, Oct 4, 5, 6, 11, 12, 13, 2011	2011_041103_0028	Critical Incident

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Registered Practical Nurses, Registered Nurses, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed resident health records and observed resident care. During the course of this inspection the inspector completed a total of five critical incident inspections. The log numbers are as follows: O-00386-11, O-001506-11, O-001955-11, O-002054-11 and O-000434-11.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

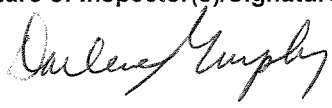
Staff failed to reassess a resident who experienced a change in condition following an injury. s.6(10)(b)
Log # O-000386-11.

Additional Required Actions:

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

Issued on this 18th day of October, 2011

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



Ontario

Ministry of Health and Long-Term Care

Ministére 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2011_041103_0028
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Sep 16, 19, 20, 21, 22, Oct 4, 5, 6, 11, 12, 13, 2011
Licensee / Titulaire de permis :	COMMUNITY LIFECARE INC 1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6
LTC Home / Foyer de SLD :	COMMUNITY NURSING HOME (PICKERING) 1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~MIKE MACDONALD~~ Metzi Lacroix

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

Ontario

Ministry of Health and Long-Term Care

Ministére 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 : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with s. 6. The compliance plan shall include how the licensee will ensure a resident with changing care needs is reassessed. Further, the plan shall include staff training to ensure policies and procedures are followed.

This plan must be submitted in writing to Inspector, Darlene Murphy at 347 Preston Street, 4th floor, Ottawa, ON K1S 3J4 or by fax at 613-569-9670 on or before October 21, 2011.

Grounds / Motifs :

1. (103)
2. Staff failed to reassess a resident who experienced a change in condition following an injury. s.6(10)(b)
Log # O-000386-11.
s.6(10)(b) (103)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 11, 2011

Ontario

Ministry of Health and Long-Term Care

Ministére 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

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
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

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

and the

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

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

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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

Issued on this 13th day of October, 2011

Signature of Inspector / Signature de l'inspecteur : Darlene Murphy

Name of Inspector / Nom de l'inspecteur : DARLENE MURPHY

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 16, 19, 20, 21, Oct 4, 5, 6, 11, 12, 13, 2011	2011_041103_0027	Complaint

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with residents, Health care Aides, Personal support workers, Registered Practical nurses, Registered Nurses, a Physiotherapist and a Physiotherapist aide.

During the course of the inspection, the inspector(s) reviewed resident health care records and observed resident care. During the inspection period, the inspector completed two complaint inspections. The log numbers are as follows: O-001153-11 and O-000084-11.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Personal Support Services

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee failed to ensure a resident's wounds were assessed weekly by a member of the registered nursing staff.
Log # O-001153-11

Additional Required Actions:

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

Issued on this 20th day of October, 2011

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

Ontario

Ministry of Health and Long-Term Care

Ministére 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2011_041103_0027
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Sep 16, 19, 20, 21, Oct 4, 5, 6, 11, 12, 13, 2011
Licensee / Titulaire de permis :	COMMUNITY LIFECARE INC 1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6
LTC Home / Foyer de SLD :	COMMUNITY NURSING HOME (PICKERING) 1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~MIKE MACDONALD~~ Metzi Macroxi

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall immediately ensure an identified resident wounds are reassessed on a weekly basis by a member of the registered nursing staff.

Grounds / Motifs :

1. The licensee failed to ensure a resident's wounds were assessed on a weekly basis by a member of the registered nursing staff.
Log # O-001153-11 (103)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 17, 2011

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

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

and the

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

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

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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

Issued on this 13th day of October, 2011

Signature of Inspector / Signature de l'inspecteur : Darlene Murphy

Name of Inspector / Nom de l'inspecteur : DARLENE MURPHY

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 30, Dec 1, 2, 15, 2011	2011_046166_0049	Follow up

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator,the Director of Care,Residents,members of the Registered Nursing staff,Personal Support Workers,members of the Housekeeping staff,the Dietitian,members of the Program department,and the Administrative Assistant.

During the course of the inspection, the inspector(s) observed four residents, reviewed identified residents' clinical records,physicians' orders, medication administration records,treatment administration records and licensee's documentation related to log #O-002249-11 and log #O-002259-11

The following Inspection Protocols were used during this inspection:

Falls Prevention

Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

Skin and Wound Care

There are no findings of Non-Compliance as a result of this inspection.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

CORRECTED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 6.	CO #001	2011_041103_0026	166
LTCHA, 2007 S.O. 2007, c.8 s. 6.	CO #001	2011_041103_0028	166
LTCHA, 2007 S.O. 2007, c.8 s. 19.	WN #1	2011_041103_0026	166
LTCHA, 2007 S.O. 2007, c.8 s. 19.	CO #002	2011_041103_0026	166
O.Reg 79/10 r. 35.	WN #1	2011_041103_0025	166
O.Reg 79/10 r. 50.	CO #001	2011_041103_0027	166

Issued on this 15th day of December, 2011

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Dec 1, 2, 16, 22, 2011; Jan 16, 2012	2011_046166_0054	Critical Incident

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Residents, the Administrator,the Director of Care, members of the Registered staff,the Dietitian and Personal Support Workers.

During the course of the inspection, the inspector(s) inspected 4 critical incidents,observed residents,reviewed residents' clinical health records and reviewed the licensee's documentation related critical incidents.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Documentation in an identified resident's clinical records noted a change in skin integrity with description of a large red and purple bruise on the upper right groin to the back of the buttocks crease.Interview with the Administrator and review of licensee's documentation confirm that the the incontinent product had been wrongly applied and caused bruising to the resident's skin.[s.3.(1)4.]Log O-002516.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee's documentation and interview with the Administrator confirmed that an identified resident was not appropriately dressed suitable to the time of day and the resident's clothing was soiled.Log O-00263-11

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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

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

Findings/Faits saillants :

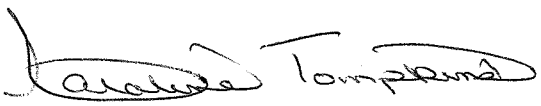
1. Review of an identified resident's plan of care and interview with the Director of Care and the Administrator establishes that the resident required a mechanical lift for all transfers.Review of licensee's documentation and interview with Administrator confirmed that the resident was not transferred in accordance with the resident's plan of care. The resident sustained an injury.Log O-002162-11.
2. An identified resident's plan of care and the resident's transfer logo did not reflect the two types of resident transfers. This intervention for transfers was not communicated to all staff members who provide direct care to the resident.Log O-002236-11.

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 care set out in the plan of care is provided to the resident as specified in the plan and to ensure that staff and others who provide direct care to a resident are kept aware of the contents., to be implemented voluntarily.

Issued on this 16th day of January, 2012

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



Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
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Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
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Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 12, 14, 20, 2012	2012_046166_0008	Critical Incident

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Resident, the Administrator and two Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed the resident's clinical health records and the licensee's documentation related to the incident.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

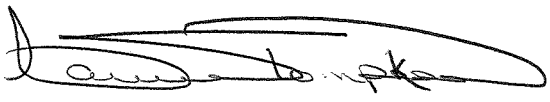
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Review of the licensee's documentation related to the investigation and interviews with staff and the resident confirm that an identified resident's rights related to dignity and respect were not promoted.[3.(1)1]

Issued on this 20th day of March, 2012

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



Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 12, 16, 19, 20, 2012	2012_046166_0007	Critical Incident

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Resident,the Administrator and two members of the Registered Staff.

During the course of the inspection, the inspector(s) reviewed the resident's clinical records and the licensee's policies related to medication administration and responsive behaviours.

The following Inspection Protocols were used during this inspection:

Medication

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following subsections:

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. Prior to this inspection there was no policy that gave direction to the nursing staff related to leaving medications at the residents' bedside. Medication Administration Policy RSL-MED-005 has been amended under section 4.5 and now reads .Ensure that oral medications are swallowed.Do not not leave medications at the residents' bedside.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

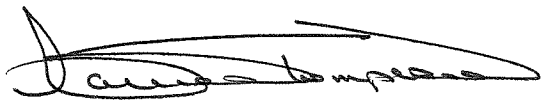
An identified resident self administered medications without the approval of the prescriber in consultation with the resident.

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 no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident., to be implemented voluntarily.

Issued on this 20th day of March, 2012

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



Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 26, 27, 28, 29, Apr 2, 3, 4, 10, 11, 12, 13, 16, 17, 18, 20, 25, 27, 2012	2012_031194_0016	Resident Quality Inspection

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

CHANTAL LAFRENIERE (194), CAROLINE TOMPKINS (166), PATRICIA POWERS (157)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Residents,family members,volunteers, Administrator, Clinical and Administrative Directors of Care, Environmental Manager, Food Service Manager, Dietary Manager, Dietitian RAI Coordinator, Physio Therapist, Program Manager,Program Assistants, Social Service Worker,Attending Physician, Registered Nurses (RN), Registered Practical Nurses(RPN), Personal Support Workers (PSW),

During the course of the inspection, the inspector(s) reviewed resident clinical health records,relevant policies,staff education records,resident charges and administrative records,committee minutes. Observation of storage and supply areas, meal services and resident care and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following subsections:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items;
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and
(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that linens are maintained in a good state of repair;

Interview with Administrator and Environmental Manager confirms that the licensee is aware of this issue and has undertaken steps to rectify.

Previous issue of Written Notification was noted in September 2011 for ripped and frayed linens.

- A blanket on resident's bed was found to have a hole in it as well as the incontinent (bed) pad being very frayed and worn
- Two identified rooms were noted to have incontinent (bed) pads frayed
- An identified room was noted to have a large tear at the top corner of the bed spread
- Two identified rooms were noted to have bed spreads being frayed
- An identified room had two holes noted in bed spread [r.89(1)(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 linens are maintained in a good state of repair., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident is cared for in a manner consistent with his/her needs as evidenced by;

Resident #150 plan of care directs that staff transferring the resident are to push the resident's wheelchair down the middle of the hallway, so that the resident's hands do not become entangled in the hand rails. The resident's clinical health record states that in March 2012 the resident was being transferred to the dining room by staff in the wheelchair and the resident sustained a bruise on right thumb and "scratched hand on hallway rails when transported". There is no evidence of further intervention until 5 days later, when it is identified that the resident has sustained an injury that required treatment.

2. Resident #150 plan of care directs that the resident requires two + persons assist for transfer - lifted mechanically with a full sling. Transfer code posted at the resident's bedside directs two person assist with a mechanical lift. Staff confirm that they assist resident up every morning. RPN confirms that the ceiling lift in the resident's room was malfunctioning for four days and staff did not get the resident out of bed for that period of time. [s3.(1)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 every resident requiring lifts or transfers is cared for in a manner consistent with his/her needs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following subsections:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The Administrator has indicated that two full bed rails are not considered to be a restraint, under the home's definition. (Restraint Policy, RSL-SAF-035,January 2010)

The following residents were observed by inspectors to have two full bed rails in place. Registered Staff confirmed the use of two full bed rails and that the residents identified were physically incapable of getting out of bed on their own.

- residents #183, #164, #176, #276, #278, #310

Plan of care for resident #183 directs the use of two full bed rails;

-no written consent was available (written consent is required by licensee's restraint policy)
-no physician's order was obtained
-no evidence that alternatives to restraining were considered. (written documentation required by the licensee's restraint policy, for alternatives to restraints.)[s.31.(2)2,4,5]

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 restraining of a resident by two full bed rails, is included in a resident plan of care, only if alternative to the restraint have been considered, a physician has ordered or approved the restraining, and the restraining of the resident has been consented to by the resident or the Substitute Decision Maker (SDM)., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. A number of resident rooms occupied by more than one resident were observed to not have sufficient privacy curtains to provide privacy;

Administrator and Environmental Manager verified that velcro had been previously tried to close the gaps, but had not been successful. The licensee is currently adapting privacy curtains with magnets to ensure privacy where curtains do not meet. The missing curtain sections had not been identified to the management of the home.

- In an identified room there is a gap of approximately 48 inches at the foot of bed (B) without a privacy curtain
- In five identified rooms privacy curtains between bed A and B do not meet where the ceiling lift track is mounted, leaving a gap that does not provide privacy to the residents
- In five identified rooms privacy curtains are missing on short track at the head of the bed, between the ceiling lift and the wall

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. As required by O.Reg 79/10, r.8(1)(a) The licensee of a long term care home shall have; plan, policy, protocol, procedure, strategy or system and ensure they are in compliance with and are implemented in accordance with all applicable requirements under the act;

As required by O.Reg 79/10, r.30(1) Every licensee of a long-term care home shall ensure that the policy for Dietary Services provides for monitoring of outcomes related to the provision of meal service.

The licensee policy DMS-NC-60 "Provision of Meal Service" (January 2009) does not provide for monitoring outcomes related to provision of meal service.

There is no evidence of monitoring of outcomes of meal service as evidenced by observation of the supper meal service.
- The supper meal service commenced at 1700 hours and the last meal provided to residents was served at 1745 hours
- Nursing staff were observed sitting at resident tables for 45 minutes waiting for food to be served by the dietary staff
- A resident's SDM voiced complaints during family interview about a an identfied resident who is regularly required to wait 45 minutes prior to being served the supper meal
- Three residents were observed to be leaving the dining room, before supper was served, voicing concerns about the delay to meal service
- Several resident's observed leaving the dining room prior to dessert being served, complaining about the delay in service
- One resident complained that the food was served cold
- Resident's at several tables were being served and fed their meals, while table mates waited for their meal[r.30(1)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 policies for dietary services to provide for monitoring outcomes of the supper meal., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices;
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device;
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others;
(d) types of physical devices permitted to be used;
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented;
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The home's policy RSL-SAF-035 "Restraint Policy" addresses the types of physical devices permitted to be used but does not identify the use of two full side rails as a restraint.[r.109.(d)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following subsections:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care;
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard;
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency;
(d) a bedside table is provided for every resident;
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The home failed to provide a firm, comfortable mattress for two identified residents #145, #999.

A complaint from staff was received about the resident's comfort related to the the mattress for resident #145. Inspector observed the mattress to be sagging in the center providing poor support.

A family concern was received for resident #999 stating that the resident was not comfortable related to the mattress. Inspector observed the mattress to be sagging in the center providing poor support.

Concerns were reported to the licensee and both surfaces were immediately replaced.[r.12.(2)(a)]

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WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16.

Findings/Faits saillants :

1. On April 04, 2012 at 1100 hours is was observed that the bedroom window in an identified room on the ground floor, that opens to the outdoors and is accessible to residents, could be opened to 91 centimeters. There was no evidence that the resident would attempt to elope through the window. The licensee was notified and the window was fixed immediately.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The Clinical Director of Care confirmed that immunizations against diphtheria and tetanus are not offered to residents at the home. [r.229.(10)3.]

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 be offered immunization against Tetanus and Diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website., to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The president of the Residents' Council stated that Residents' Council does not review the meal and snack times in the home.[r.73.(1)2]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. Resident #183 was noted to have two full bed rails. A monitoring sheet for positioning was not in place. The plan of care directs staff to check for safety every hour, and encourage resident to assist staff with repositioning. The plan of care did not direct staff to reposition resident every two hours as required in the restraint policy.[r.110.(2)4]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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

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

Findings/Faits saillants :

1. The written plan of care for resident #276 identifies that the resident is provided personal care at 0630 hours. The SDM has expressed that resident #276 not be provided personal care at 0630 hours. The resident's plan of care is not based on an assessment of her needs and preferences.[s.6.(2)]

2. The licensee failed to ensure that staff who provide direct care to residents have convenient and immediate access to the residents' plans of care as evidenced by;

The Director of Care reported that PSW's and Registered staff are provided with password access to the computerized care plans.

Three PSW staff on an identified unit confirmed that they do not have password access to the computer where residents' care plans are located.

Resident "Kardex" is accessible to the direct care staff in each home area. Several Kardexes refer staff to "see care plan"for further direction and interventions.

- Kardex for resident #150 informs staff that resident is incontinent but directs them to "see care plan" for required interventions
- Kardex for resident #183 for activity/program interventions does not provide program interests but states "See Care Plan"
- Kardex for resident #369 identifies that the resident requires interventions for behaviour but states "See Care Plan"[S.6.(8)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following subsections:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3);
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The Administrator confirmed that the resident satisfaction survey is out sourced to a company outside the home. The president of the Residents' Council and the Administrator confirms that the licensee does not seek the advice of Residents' Council in developing and carrying out the survey and in acting on its results.[S.85(3)(4)(a)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following subsections:

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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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 are maintained in a safe condition and in a good state of repair, as evidenced by the following;

- An identified resident bathroom door had holes noted on front and back of the door, with potential for wood splinters to be a source of injury to residents.
- An identified tub room was noted to have discoloured grout on the floor and wall tiles, with potential infection control hazard related to improper cleaning
- An identified tub room has a hole in the wall exposing pipes beside the toilet and a hole in the wall under the sink, with potential for infection control related to inability to properly clean area.
- An identified tub room had water pooling on the floor by the Parker bath, potential for injury related to falls.
- An identified tub rooms tub molding is loose, potential for infection related to inability to clean properly.
- An identified tub rooms metal drain cover in floor is not secured, potential for injury related risk of falls.

2. The licensee has failed to ensure that the home furnishings and equipment are kept clean and sanitary as evidenced by;

- In an identified tub room, the material backing of the two shower chairs(white) were noted to have water and black discolouration (mold) in the folds
- In five identified rooms the privacy curtains between the beds were noted to be soiled

Issued on this 3rd day of May, 2012

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 2, 3, 12, 18, 19, 2012	2012_046166_0015	Critical Incident

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrative Director of Care and the Clinical Director of Care.

During the course of the inspection, the inspector(s) reviewed the resident's clinical health records.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Resident's(#01)plan of care indicated that the resident was to be transferred with the aid of a mechanical lift ,two staff assist using a full sling.On the day of the incident the resident was transferred mechanically using a sit to stand sling which allowed the resident to slip through the sling sustaining a laceration to the head.

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 care set out in plan of care is provided to the resident as specified in the plan., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

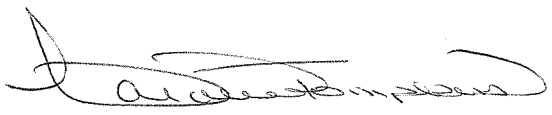
1. Resident(#01) was transferred mechanically using an incorrect sling causing the resident to slip through the sling ,sustaining a laceration to the head.

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 staff use safe transferring and positioning devices or techniques when assisting residents., to be implemented voluntarily.

Issued on this 19th day of April, 2012

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



Ontario

Ministry of Health and Long-Term Care

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Ministére de la Santé et des Soins de longue durée

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 2, 12, 13, 18, 19, 2012	2012_046166_0013	Complaint

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Resident(#2), the resident's primary Physician, the resident's Advocate, the Administrator, Registered staff, Personal Support staff, Housekeeping staff and Program staff.

During the course of the inspection, the inspector(s) observed the resident's room and reviewed the resident's clinical records.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

There are no findings of Non-Compliance as a result of this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Ontario

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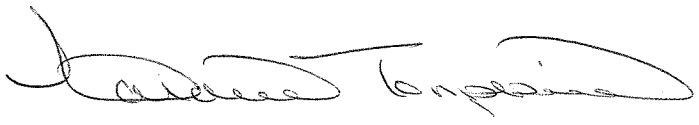
Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance 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.

Issued on this 19th day of April, 2012

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



Ontario

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 2, 3, 13, 18, 19, 2012	2012_046166_0014	Complaint

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

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1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Resident, the resident's Advocate, Registered staff, Personal Support Staff, a member of the Housekeeping staff and the Environmental Supervisor.

During the course of the inspection, the inspector(s) reviewed the resident's clinical records, observed the resident's room and observed the resident at meal times.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

There are no findings of Non-Compliance as a result of this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Ontario

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

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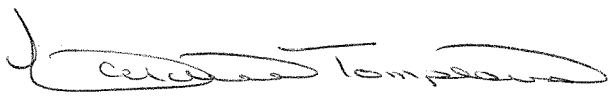
Issued on this 19th day of April, 2012

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



Ontario

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 18, 24, 2012	2012_046166_0016	Critical Incident

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

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

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Resident,the co Resident,a member of the Registered staff and a member of the Personal Support staff

During the course of the inspection, the inspector(s) observed the resident , reviewed the resident's clinical records and the licensee's incident report.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

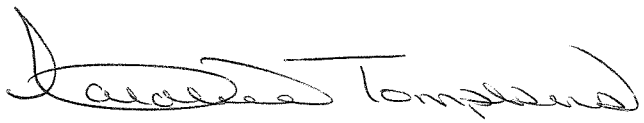
s. 107. (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 79/10, s. 107 (2).

Findings/Faits saillants :

1. This incident documents resident to resident abuse ,a requirement for immediately reporting to the Director.The Ministry of Health and Long Term Care was not notified within the legislative time frame.

Issued on this 24th day of April, 2012

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



Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 29, Nov 7, 14, 2012	2012_178102_0003	Complaint

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

WENDY BERRY (102)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Environmental Manager, several staff members, visitors and residents.

During the course of the inspection, the inspector(s) checked many resident areas in the older sections of the long term care home for moisture infiltration during a period of wet weather. During the inspection, issues that were not related to the complaint were identified including security systems, privacy curtains and access to point of care hand hygiene agents. The onsite inspection occurred on October 29, 2012.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. In several areas of the long-term care home, the resident-staff communication and response system can not be easily seen, accessed and used by by residents, staff and visitors:
- pull cords were missing from activator switches provided in the activity room across from rooms P 1 / P3; in the lounge at the end of "Pine" wing; and from 3 switches located within the "Knotty Pine" and "Linden" dining rooms. The switches are difficult to access without the cords due to their height above the floor surface, most are in excess of 60 inches.
- pull cords connected to activator switches at a tub and a toilet in the Pine wing's "Bathing Area" are not accessible to residents and/or staff at the toilet and the bath tub. The cords are "out of reach" when using either fixture.
- activator switches are located behind doors in the lounge across from the Linden nursing station and in the activity room located across from rooms P1/P3. [s. 17.(1)(a)]

.

2. The resident staff communication and response system provided in the "Pine" wing uses sound to alert staff.
The level of sound was not audible to staff when the "tone off" button was activated on the audio visual panel that is provided at the Pine wing nursing station. The tone off button allowed the audio component of the calls to be shut off.
[s. 17.(1)(g)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident-staff communication and response system activator switches can be easily seen and accessed in all areas of the home; and that the sound for active calls on the system remains audible to staff until cancelled at the point of activation, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following subsections:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Findings/Faits saillants :

1. The audible tone for the resident accessible door leading from the Pine wing corridor to the outside can be silenced by by pressing the "tone off" button on the audio visual panel at the nursing station located within the wing.
The door is not equipped with an audible door alarm that allows calls to only be cancelled at the point of activation.

2. The resident accessible door leading to/from the long term care home into the attached retirement home is not equipped with an audible door alarm; and is not connected to the resident-staff communication and response system or to an audio visual enunciator at the closest nursing station.
The attached retirement home is not a secure area outside of the long-term care home.

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 all resident accessible doors leading to stairways and non secure areas outside of the long term care home, which includes the retirement home, are equipped with the required audible door alarm that can only be cancelled at the point of activation, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. Hand hygiene dispensers are provided in corridors and on some carts used by staff.

Access to point of care hand hygiene products is not provided within residents' bedrooms.

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 point of care hand hygiene agents are accessible in all resident bedrooms, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

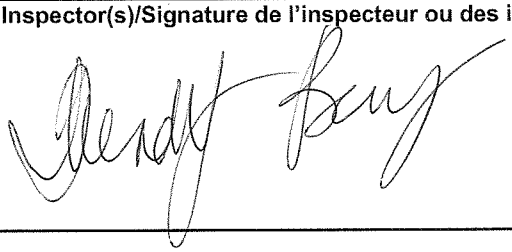
Findings/Faits saillants :

1. Sufficient privacy curtains to provide privacy are not provided at the foot board end of the bed closest to the door in an identified 2 bed room.

The bed adjacent to the window can only be accessed by passing through the section of the bedroom that is equipped with privacy curtains and tracking for the resident who occupies the bed closest to the door.

Issued on this 14th day of November, 2012

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



Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 17, 2012	2012_038197_0037	O-002354-12	Complaint

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 10 & 11, 2012

Further information was received from the home via email on the following dates: December 11, 12, 13 & 14, 2012

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Nutrition Manager, food service workers and residents.

During the course of the inspection, the inspector(s) reviewed an internal investigation file, the Nutrition Manager hours for September, October and November 2012 and observed a breakfast and supper meal service in the main dining room.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Dining Observation

Sufficient Staffing

There are no findings of Non-Compliance as a result of this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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.

Issued on this 17th day of December, 2012

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

Jessica Pattin, RD

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 2, 2013	2013_196157_0009	000862, 000973, 001668, 001347	Critical Incident System

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

PATRICIA POWERS (157)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 12, 13, 14, April 5, 2013

During the course of this inspection the following critical incidents were inspected: Log #O-000862-12, CI#2693-000010-12; Log #O-000202-12, CI#2693-000022-13; Log #O-001668-12, CI#2693-000033-12.

During the course of the inspection, the inspector(s) spoke with Director of Care, Director of Quality in Nursing, Clinical Nurse Specialist, 2 Registered Nurses, 1 Registered Practical Nurse

During the course of the inspection, the inspector(s) Reviewed the clinical health records for 3 residents, reviewed critical incident reports and related facility investigation reports, reviewed facility policies related to Resident Safety: Zero Lifting, Safe Transfers (Resident Services Manual - Policy #RSL-SAF-025, June 26, 2012), Reporting of Abuse and Neglect (Human Resources Manual - Policy HRM-POL-003, May 29, 2012), Behaviour Management (Resident Services Manual - Policy RSL-BM-010, July, 2012), reviewed procedures for use of bedside lift logos.

The following Inspection Protocols were used during this inspection:
Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. Log #001668-12
The Kardex and Plan of Care for resident #07 provides direction for lifting/transfer with a mechanical lift.
The plan of care failed to provide clear direction related to the type of sling to be used in the lift. Staff using the incorrect sling resulted in the resident sustaining a fall. [s. 6. (1) (c)]

2. Log #000202-13
Personal Support Worker's responsible for the provision of personal care to resident #12 failed to assess and report a change in the resident's skin condition. The resident's skin condition was not promptly reported to the registered nursing staff to ensure early detection of risk, follow up and treatment of the skin condition.
Staff involved in the different aspects of care of resident #12 failed to collaborate with each other in the assessment of the resident. [s. 6. (4) (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 plans of care for resident requiring transfer with the use of a mechanical lift, clearly identify the type of sling to be used to ensure safe transfer, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 107 (4).
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. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident 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. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. Log #000862-12
Resident #11 was found to have sustained an injury to the hand resulting in the need for subsequent diagnostic tests to investigate the injury.
The Critical Incident report was not submitted until 39 days after the injury occurred.
The licensee failed to submit a report within 10 days of becoming aware of the incident. [s. 107. (4)]

Issued on this 2nd day of July, 2013

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 8, 2013	2013_196157_0010	001687, 002236	Complaint

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

PATRICIA POWERS (157)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 12, 13, 14, April 5, 2013

During the course of this inspection, the following complaint logs were inspected: Log #001687-12, Log #002236-12,

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care, Corporate Director of Nursing Services, Director of Quality in Nursing, Clinical Nurse Specialist, Food Service Manager, Food Service Supervisor, 3 Registered Nurses,1 Registered Practical Nurse, 2 Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed clinical health records for identified residents, observed staff:resident interactions, observed care and services provided to residents, reviewed dietary and administration staffing deployment, reviewed facility policies related to Caring for Residents with Responsive Behaviours and Abuse and Neglect.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Sufficient Staffing

There are no findings of Non-Compliance as a result of this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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.

Issued on this 8th day of April, 2013

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

Pat Rivers #157.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 19, 2013	2013_196157_0029	000560-13	Complaint

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

PATRICIA POWERS (157)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 11, 12, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator and the Director of Care.

During the course of the inspection, the inspector(s) observed the posting of required information in the home, reviewed the licensee's policy and procedure related to the management of complaints and concerns.

The following Inspection Protocols were used during this inspection:
Admission Process
Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. A complaint related to resident #01 was forwarded to the Administrator of the home by e-mail on three identified dates. A voice mail related to the same issue was left for the Administrator.
There is no evidence that copy of the complaint received by e-mail was forwarded to the Director. [s. 22. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The POA for resident #01 was contacted by a representative of the home for authorization to purchase a new piece of personal care equipment for the resident. When the POA visited the home he identified that the equipment previously purchased for the resident could not be located. The POA states there has been no response from the home related to the whereabouts of the equipment belonging to the resident.

E-mail records provided indicate that three e-mail messages and one voice message was left for the Administrator of the home inquiring about this matter with no response.

Current Administrator in the home at the time of this inspection was not employed at the home at the time the complaint was received and is unfamiliar with this situation. The Administrator confirmed that there is no record of this matter in the home. [s. 101. (1) 1.]

2. The licensee failed to ensure that a response was provided to the person who made a complaint. [s. 101. (1) 3.]

3. The licensee failed to ensure that a documented record was kept indicating the nature and date of a complaint, the type of action taken to resolve the complaint, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, any response made in turn by the complainant. [s. 101. (2)]

Issued on this 20th day of December, 2013

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 19, 2013	2013_196157_0029	000560-13	Complaint

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

PATRICIA POWERS (157)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 11, 12, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator and the Director of Care.

During the course of the inspection, the inspector(s) observed the posting of required information in the home, reviewed the licensee's policy and procedure related to the management of complaints and concerns.

The following Inspection Protocols were used during this inspection:
Admission Process
Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. A complaint related to resident #01 was forwarded to the Administrator of the home by e-mail on three identified dates. A voice mail related to the same issue was left for the Administrator.
There is no evidence that copy of the complaint received by e-mail was forwarded to the Director. [s. 22. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The POA for resident #01 was contacted by a representative of the home for authorization to purchase a new piece of personal care equipment for the resident. When the POA visited the home he identified that the equipment previously purchased for the resident could not be located. The POA states there has been no response from the home related to the whereabouts of the equipment belonging to the resident.

E-mail records provided indicate that three e-mail messages and one voice message was left for the Administrator of the home inquiring about this matter with no response.

Current Administrator in the home at the time of this inspection was not employed at the home at the time the complaint was received and is unfamiliar with this situation. The Administrator confirmed that there is no record of this matter in the home. [s. 101. (1) 1.]

2. The licensee failed to ensure that a response was provided to the person who made a complaint. [s. 101. (1) 3.]

3. The licensee failed to ensure that a documented record was kept indicating the nature and date of a complaint, the type of action taken to resolve the complaint, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, any response made in turn by the complainant. [s. 101. (2)]

Issued on this 20th day of December, 2013

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 20, 2014	2014_196157_0003	000284,000107,001033	Complaint

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

PATRICIA POWERS (157), MARIA FRANCIS-ALLEN (552)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 21, 22, 23, 2014

The purpose of this inspection was to conduct a complaint inspection of the following logs:
O-000107-13, O-001033, O-000284-13

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Director of Quality Nursing, Environmental Services Manager, Food Service Manager, Clinical Nurse Specialist, RAI Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers and residents.

During the course of the inspection, the inspector(s) toured and observed the condition and cleanliness of the physical facility, observed meal service in the main dining room, observed food serving temperatures and procedures for maintaining and monitoring food temperatures, reviewed minutes of the home's Food Committee, observed quantity and quality of linen supplies in resident rooms, care areas and storage areas, reviewed environmental services policies and procedures relating to administration of environmental services and management of linen supplies, reviewed clinical health records of identified residents, observed resident cleanliness and grooming, observed practices and records related to the use of bed/chair alarms, observed staff to resident interactions, observed resident care practices.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Personal Support Services

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to 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
(b) cleaned as required.
During a tour of the home on January 22, 2014 the following was observed in the identified shared resident bathrooms:
- room M14 (2 beds) two denture cups and two toothbrushes not clean, not labelled
- room B22 (2 beds) soap dish with used soap bar not labelled, two denture cups not labelled
- room B7 (2 beds) two toothbrushes not labelled, one hair brush not clean and not labelled
- room B9 (2 beds) three toothbrushes not clean and not labelled, two denture cups not labelled, one hair brush not clean, not labelled
- room B15 (2 beds) two denture cups not labelled
- room L11 (2 beds) two toothbrushes not labelled, two denture cups not labelled
- room L9 (4 beds) three toothbrushes not labelled, two denture cups not labelled
- room L10 (2 beds) two toothbrushes not labelled, two denture cups not labelled
- room L3 (2 beds) used bar soap not labelled, two toothbrushes not labelled
- room P3 (2 beds) two toothbrushes not labelled
- room P9 (4 beds) three toothbrushes not labelled, two denture cups not labelled [s. 37. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a sufficient supply of clean linen, face cloths and bath towels are always available for use by the residents and to ensure that linen, face cloths and bath towels are maintained in a good state of repair.

Related to log #O-000107-13 and #O-001033-13
During a tour of the home on January 21, 2014 the linen supply carts on Maple, Birch and Linden units appeared to have an inadequate linen supply readily available to staff and residents.
During a tour of the home on January 22, 2014 at 1400 hrs the following linen supplies were observed:
- Maple unit (linen room) - no towels, 4 facecloths, 4 pillow cases, no blankets
- Resident rooms: M4 (4 beds) - 1 face cloth, no towels available; M3 (4 beds)- no towels or face cloths available; M14 (2 beds) - 3 face cloths, no towels available; B19 (1 bed) - no towels or face cloths available; B23 (2 bed) - no towels, one face cloth available; B22 (2 beds) - no towels, 1 face cloth available; L19 (2 beds) - 1 face cloth, no towels available; L16 (2 beds) - no towels or face cloths available; L12 (2 beds) - no towels or face cloths available.

Interviews conducted with staff at 1430 hrs related to the availability of linen supplies indicated the following:
- Staff #109 stated that there is not always enough bed linen, bath towels and face cloths available for resident care. Stated that the laundry staff restock the linen cupboards every shift but there are times that nursing staff have to go to the laundry room to request additional linen supplies.
- PSW on Maple unit stated that staff are frequently short of linen to provide resident

care.
- Staff #117 stated that there is a short supply of towels and face cloths especially on the day shift and stated that this concern has been communicated with the home.
- Staff #101 and #102 reported that the availability of linen supplies has been an ongoing concern expressed by staff and residents.

The Administrator and Director of Care stated they are aware of concerns related to linen supplies and are aware that staff are hiding products in residents' rooms for future use. [s. 89. (1) (b)]

2. Related to log #O-000107-13 and #O-001033-13
Interviews conducted with residents at 1320 hrs related to the availability and condition of linen supplies indicated the following:
- Resident #02 stated that occasionally the bed sheet is ripped and that at times the resident has had to wait 1/2 hour to get fresh bath towels and face cloths.
- Resident #03 stated that there are occasions when there are not enough bath towels and face cloths to meet the resident's needs.
- Resident #06 reported always being without a sufficient supplies of towels, face cloths and bed linens and stated that linen is in a poor state of repair. Resident #06 reported showing the linens to staff to demonstrate the poor condition they are in.

There is potential risk of harm to residents and the scope of non compliance is widespread. This non-compliance was previously issued as a Written Notification in September, 2011 and as a Written Notification and Voluntary Plan of Correction in March, 2012. This inspection was related to a complaint received in February, 2013 and a complaint received in October, 2013. [s. 89. (1) (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 a sufficient supply of clean linen, face cloths and bath towels are available for use by residents and to ensure that linen, face cloths and bath towels are maintained in a good state of repair, to be implemented voluntarily.

Issued on this 20th day of February, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 10, 2014	2014_196157_0002	000228,000845,001347,000973	Critical Incident System

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

PATRICIA POWERS (157), MARIA FRANCIS-ALLEN (552), MATTHEW STICCA (553)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 21, 22, 23, 2014

The purpose of this inspection was to conduct a critical incident inspection for the following logs:
O-000973-12, O-0001347-12, O-002355-12, O-000228-13, O-000697-13, O-000845-13, O-001152-13, O-001235-13, O-000040-14

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Director of Quality Nursing (DQN), Clinical Nurse Specialist (CNS), RAI Coordinator, Behaviour Support Program Coordinator (BSO), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents.

During the course of the inspection, the inspector(s) reviewed the clinical health records of identified residents, reviewed the home's policies and procedures related to Falls Prevention and Management, Responsive Behaviours and Abuse and Neglect, reviewed records of education programs related to abuse and neglect and education session attendance records, reviewed the home's investigation records related to falls, responsive behaviours and incidents of abuse and neglect, reviewed behaviour monitoring procedures and interventions for identified residents, observed staff to resident interactions, observed the provision of resident care.

The following Inspection Protocols were used during this inspection:
Admission Process
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for resident #03 set out clear direction to staff and others who provide direct care to the resident.

Related to Log #O-000973-12, Critical Incident Report:
The plan of care for resident #03 indicates that the resident was known to demonstrate responsive behaviours which resulted in risk of harm to other residents. The written plan of care provided the following direction:
- "Remove resident from any stressful situation" but failed to provide clear directions related to the situations that would be stressful to this resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the written plan of care for resident #01 set out clear direction to staff and others who provide direct care to the resident.

Related to log #O-000040 Critical Incident Report:
Critical Incident Report states that on an identified date resident #01 experienced two falls. The resident was assessed and was transferred to hospital for further assessment. The resident was admitted to hospital for treatment the home was subsequently advised that the resident was deceased.
Resident #01's clinical health record indicates the following:
- The initial Physiotherapy assessment of resident #01 identified the resident as being a "high risk" for falls.
- The written plan of care for Resident #01 under the Falls/Balance focus, identified the resident as being a "low risk" for falls.
- The action plan section of the home's Post Fall Investigation Record, identified Resident #01 as being a "medium risk" for falls.
- Four Falls Risk Assessments were completed for resident #01 on identified dates. Each assessment identified the resident as being a "high risk" for falls. The outcomes of these assessments were not included in the development and implementation of the plan of care for Resident #01 and as a result the plan of care failed to provide clear direction related to the resident's risk of falls. [s. 6. (1) (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 written plans of care for residents:
- identified as demonstrating responsive behaviours and;
- identified as being at risk for falls
provide clear direction to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

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. Related to Log #O-000228-13, Critical Incident Report:
The licensee failed to ensure that an alleged, suspected or witnessed incident of abuse and neglect of resident #22 was immediately investigated.
The Critical Incident Report identifies the receipt of a report from a family member who witnessed PSW neglect of resident #22 and witnessed the PSW being verbally abusive to the resident and to family members:
- when the resident waited in excess of an hour for assistance to the bathroom; and
- when the PSW responsible for the resident's care complained about already toileting the resident, about the number of residents the employee is required to care for and suggested that the family provide the resident's care.
A further written complaint from the resident's family confirms the information reported in the CI Report.
The Critical Incident Report identified that the alleged incident occurred on the same day the report was submitted.
The home's incident investigation and interview notes indicate that the investigation and interviews were not commenced until five days after the incident.

A meeting held with family members of resident #22 in order to review the incident/investigation and follow up actions. Meeting minutes indicate indicate the following:
- apologies were offered from the Administrator for the delay in resolving the matter
- Administrator stated that the individual involved in the incident was part time which added to the delay in completing the investigation
- Administrator stated "we take ownership in that we should have communicated with you more effectively"
- In response to the family concerns, the Administrator stated, "Yes we dropped the ball" [s. 23. (1) (a)]

2. Related to Log #O-000228-13, Critical Incident Report:
The licensee failed to report to the Director the results of the investigation into the allegations of neglect and verbal abuse of resident #22 and the actions taken as a result of the investigation.
The Critical Incident report identifies a report from a family member about witnessing an identified PSW neglect of resident #22 and the PSW being verbally abusive to the resident and to family members.
There is no evidence that the results of the investigation of the alleged incident or the actions taken were reported to the Director. [s. 23. (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:
- alleged, suspected or witnessed incidents of abuse and neglect of residents are immediately investigated
- the results of investigations into allegations of neglect and abuse and actions taken are reported to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Related to Log #O-000845-13, Critical Incident Report:
The licensee failed to immediately notify the Director when there were reasonable grounds to suspect that a resident was physically abused by a staff member resulting in harm to the resident.

The Critical Incident report identifies an incident of a staff member physically abusing a resident on an identified date when a PSW was witnessed and admitted to striking resident #23 on the hand in response to the resident punching the staff member. The incident resulted in an injury to the resident. There is no evidence that the Director was immediately notified. [s. 24. (1)]

2. Related to Log # O-002355-12, Critical Incident Report:
The licensee failed to immediately report to the Director, the suspicion of abuse of a resident by anyone that resulted in physical harm to the resident and the information upon which the suspicion is based.

The Critical Incident Report identifies that an incident of resident physical abuse of another resident occurred on an identified date when resident #31 grabbed a co-resident on the lower arms resulting in the co-resident sustaining an injury. There is no evidence that the Director was immediately notified.
The Critical Incident Report incorrectly categorizes this incident as "Other" when the circumstances provided clearly categorize it as "Abuse/Neglect".

Related to Log #O-000697-13, Critical Incident Report:
The Critical Incident Report identifies that an incident of resident physical abuse of another resident occurred on an identified date resulting in the co-resident sustaining an injury. There is no evidence that the Director was immediately notified. [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 when there are reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident, the suspicion and the information upon which it is based is immediately reported to the Director, to be implemented voluntarily.

WN #4: 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. Related to Log#O-002355-12, Critical Incident Report:

The licensee failed to identify the behavioural triggers for resident #31 who demonstrated responsive behaviours.

The Critical Incident reports that on an identified date, resident #31 struck a co-resident resulting in the co-resident sustaining an injury.
A review of the Behavioural Assessment Tool (BAT) for resident #31 indicates that there were no triggers or interventions provided for the following identified behaviours:

- Agitated Behaviour (evaluated as high risk)
- Verbally Aggressive/ Angry Behaviour (evaluated as high risk)

- Physically Aggressive/ Angry Behaviour (evaluated as high risk)
As a result of the failure to identify triggers and appropriate interventions, the plan of care for resident #1 failed to reflect the current needs of the resident.

The Multidisciplinary Progress Notes for resident #31 for an identified period, identifies 6 incidents of physical aggression.

Staff interviews conducted by the inspector identified the following:
- Staff #114 reported that resident #31 was part of the BSO program. Staff member identified known behaviours demonstrated by the resident.
- Staff #102 reported that the home had difficulty identifying triggers for resident #31's behaviours
The plan of care for resident #01 failed to identify a known trigger demonstrated by resident #31.

The plan of care directed staff to remove the resident from the situation causing anger and distress, and to remove the resident from any stressful situation. The direction failed to provide specific information related to what situations would trigger resident #31's anger and distress and what situations the resident could potentially find stressful. [s. 53. (4) (a)]

2. Related to Log#O-002355-12, Critical Incident Report:

The licensee failed to take actions to respond to the needs of resident #31's responsive behaviours including assessments, reassessments and interventions. The Behavioural Assessment Tool (BAT), failed to identify triggers for resident #31's behaviours and failed to identify appropriate interventions to manage the resident's responsive behaviours which were identified as high risk, including agitation, verbal aggression and physical aggression.

The MDS assessment indicates that Resident #31 was assessed as demonstrating responsive behaviours and being an appropriate admission to the BSO program. However, the BAT completed for the resident was the only assessment conducted for the duration of the resident's stay in the home. The home failed to assess and reassess resident #31 who was demonstrating aggressive responsive behaviours.

Resident #31's written plan of care provided the following direction:
Focus: Verbally abusive behaviour - is verbally abusive, monitor for signs of anger or

distress. Remind Resident #31 that inappropriate language is unacceptable.
Focus: Physically abusive behaviour - is physically abusive, monitor for signs of anger or distress and remove Resident #31 from the situation.

Resident #31's progress notes for an identified period, do not provide any documentation related to the resident's response to interventions or the effectiveness of the interventions. Progress notes identify 3 occasions when the resident demonstrated verbally or physically aggressive behaviours directed towards staff or co-residents:

Incident #1 - Resident #31 in nursing station and got a book, staff tried to retrieve book. Resident #31 got upset and grabbed staff's necklace and scratched the staff's hand with nails.
- No indication of the application of interventions or the resident's response to any interventions used.

Incident #2: Verbal argument between Resident #31 and co-resident, argument took place in the front lobby.
- No indication of the application of interventions or the resident's response to any interventions used.

Incident #3: Resident #31 struck a co-resident multiple times. Staff removed Resident #31 from the altercation.
- The plan of care failed to provide staff with interventions to prevent the altercation. Planned interventions directed staff only to remove resident #31 from the situation, which they did but only after the altercation occurred. [s. 53. (4) (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 for each resident demonstrating responsive behaviours, behavioural triggers are identified where possible and actions are taken to respond to the needs of the resident including assessments, reassessments and interventions, to be implemented voluntarily.

WN #5: 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. Related to Log #O-000040-14, Critical Incident Report:
The licensee failed to ensure, where the Act or Regulation requires the licensee to have, institute or otherwise put in place a plan, protocol, procedure, strategy or system, that such plan, protocol, procedure, strategy or system any plan, policy, procedure, strategy or system was complied with.

Falls Prevention Policy, ID RSL-SAF-055 directs the following:
Procedures and Management of Complications:
- residents identified as medium and high risk must have the problems with interventions documented on the plan of care and those at high risk noted on the daily report. The Care Plan will be reviewed and updated quarterly or as the resident's status changes such as with re-admission from hospital.

The home failed to comply with the established policy as evidenced by the following:
- The Physiotherapy initial assessment for resident #01 indicated that this resident was a "high risk" for falls.
- The written plan of care for resident #01 under the Falls/Balance focus identified the resident as being a "low risk" for falls.
- The CI report indicates that resident #01 experienced a fall on an identified date. The home's post fall investigation report indicated that the resident was now assessed to be at "medium risk" for falls.
The written plan of care was not revised to accurately reflect resident #01's risk for falls and associated interventions. [s. 8. (1)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. Procedures for initiating complaints to the licensee was not posted at the time of review by the inspector. Procedures were subsequently posted by the Administrator. [s. 79. (3) (e)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. Related to Log #O-000228-13, Critical Incident Report:

The licensee failed to ensure that resident #22's SDM was notified of the results of the investigation of an alleged abuse or neglect investigation immediately upon the completion.
The Critical Incident report identifies a report from a family member who witnessed PSW neglect of resident #22 and the PSW being verbally abusive to the resident and to family members.
A further written complaint confirms the information reported.
A meeting held with family members of resident #22 in order to review the incident/investigation and follow up actions. Meeting minutes indicate the following:
- the Administrator expressed apologies for the delay in resolving the matter
- a family requested an explanation of the investigation and expressed that calls were made to the home weekly by a family member with no response from the home
- the Administrator stated that the individual involved in the alleged incident was part time which added to the delay in completing the investigation
- a family member stated that there was no response to her calls over a three week period
- the Administrator responded "we take ownership in that we should have communicated with you more effectively"
- family members expressed surprise that they visited and saw the employee back at work
- Administrator replied, "Yes we dropped the ball"
- Family member stated "So, I still haven't had an outcome of the investigation re: validation of the abuse"
- Administrator responded that the employee's "actions were inappropriate and this was managed." and that the "employee was re educated to the expectations of the home" [s. 97. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. Related to log #O-000845-13, Critical Incident Report:
The licensee failed to ensure that the appropriate police force was immediately notified of the alleged, suspected or witnessed incident of physical abuse of resident #23 by a staff member.
The Critical Incident report identifies an incident of a staff member physically abusing a resident when a PSW was witnessed and admitted, to striking resident #23 on the hand in response to the resident striking the staff member.
The appropriate police force was not immediately notified of the witnessed incident of abuse. The CI report indicates that Durham Regional Police were contacted by the home five days after the incident. Police visited the home and no charges were laid.
[s. 98.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. Related to Log #O-000228-13, Critical Incident Report:

The licensee failed to submit a copy of a written complaint to the Director along with a written report documenting the response the licensee made to the complainant.

The Critical Incident report submitted on an identified date identifies a report from a family member of resident #22 who witnessed a PSW neglect resident #22 and witnessed the PSW being verbally abusive to the resident and to family members.

The Administrator received two detailed written complaints related to the reported incident.

There is no evidence that the licensee submitted a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant. [s. 103. (1)]

WN #10: 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. Related to Log #000228-13, Critical Incident Report:
The licensee failed to report to the Director, the names of staff members who were present at or discovered an incident of verbal abuse and neglect of a resident.

The Critical Incident identifies a report from a family member of resident #22 who witnessed a PSW neglecting a resident and being verbally abusive to the resident and to family members.
The name of the PSW alleged to have been involved with the incident was not reported to the Director. [s. 104. (1) 2.]

2. Related to Log #O-000228-13, Critical Incident Report:

The licensee failed to ensure that the report to the Director provided the outcome or current status of the individual involved in the incident.

The Critical Incident identifies a report from a family member of resident #22 who witnessed a PSW neglecting a resident and being verbally abusive to the resident and to family members.
The Critical Incident report provided an inaccurate report of actions taken in response to this incident and the analysis and follow up action taken. [s. 104. (1) 3.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act. O. Reg. 79/10, s. 225 (1).
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act. O. Reg. 79/10, s. 225 (1).
3. The most recent audited report provided for in clause 243 (1) (a). O. Reg. 79/10, s. 225 (1).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 225 (1).
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits saillants :

1. The fundamental principle, Section 1 of the LTCHA, was not posted at the time of the inspection. [s. 225. (1) 1.]

2. The Ministry's toll-free number for making complaints about the home, and the hours of service were not posted at the time of the inspection. [s. 225. (1) 4.]

Issued on this 11th day of March, 2014

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

Pat Powers #157

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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347 Preston St 4th Floor
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OTTAWA ON L1K 0E1
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Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 24, 2014	2014_360111_0025	000624, 000221	Complaint

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road 3rd Floor PICKERING ON L1V 1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 1-3, 2014

2 complaint inspections (log# 000221 & 000629) were completed.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the resident, a family member, Physiotherapy Assistant (PTA),Restorative Care Aide (RCA), Registered Nurse(RN), Registered Practical Nurses(RPN), and Personal Support Workers(PSW).

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Reporting and Complaints

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure the written plan of care for Resident #1 was provided related to positioning.

Observation of Resident#1 on a specified date indicated the resident was in bed, and the resident's head was improperly positioned. A small positioning pillow was located on the floor to the right side of the bed. The resident rang the call bell at the inspectors direction and a PSW entered the room, turned off the call bell and proceeded to pick up the pillow that was on the floor and placed the pillow on the residents bed). The PSW repositioned the resident after prompted by the inspector that the resident was improperly positioned and the positioning pillow was not used.

Interview of Resident #1 indicated the resident required pillows for repositioning while in bed and when up in wheelchair due to lack of trunk support.

Review of the care plan (current) for Resident #1 indicated under bed mobility, the resident requires full staff assistance with positioning related to diagnoses. The interventions included:staff to turn and reposition every two hours, and use pillows to aid in positioning and comfort. [s. 6. (7)]

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 the written plan of care is provided to residents related to positioning, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system was accessible for Resident#1 use at all times.

Observation of Resident#1 on a specified date for a 4 hour period indicated the call bell was placed in the residents' lap towards the right side, inaccessible to the resident due to weakness. Interview of Resident #1 indicated sometimes they have "to wait a long time for staff to respond to calls". When the call bell was provided to the resident and the resident activated the call bell, a PSW responded in a timely manner. The PSW then clipped the call bell to the residents' right upper thigh area of pants (where the resident could not reach).

Observation and interview of Resident #1 on the following day indicated the resident was up in a mobility aide. The call bell was left on the resident's bed (not accessible to the resident). Interview of a family member (who was visiting the resident at the time) indicated upon arrival, the resident's call bell was not within the residents' reach. [s. 17. (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 the resident-staff communication and response system is accessible to all residents at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Review of the current care plan for Resident #1 indicated the resident is diagnosed with an infectious condition requiring the use of contact precautions to notify visitors and staff of resident's precautions (including staff to wear gown and gloves when providing care and staff to perform hand hygiene after contact with resident, and staff to designate a sling and commode for use).

Interview of the DOC indicated that Resident #1 has a sling that is kept on the back of resident door and a commode designated for use due to diagnosis and is normally stored in the shower room.

Observation of Resident#1 room on a specified date for a 4 hour period indicated there was personal protective equipment (PPE's) (yellow gowns and gloves) available and a contact precautions signage posted directing staff which PPE's to use when performing personal care. The resident's bathroom had an unlabelled denture cup on the counter and this is a shared bathroom. Observation of Resident #1 on the following day indicated there was PPE's available and a contact precautions signage on the door. The resident was up in a mobility aide after being toileted with assistance of two PSW's. One PSW remained in the room to clean the soiled commode. The PSW was observed only wearing gloves and no gown. The PSW then asked the visiting family member to push down on the commode seat seat without the use of any PPE's. The PSW then proceeded to clean the soiled commode in the resident's washroom without wearing a gown as directed on the contact precautions. The commode was left in the shared washroom and was not labelled as designated for use only for Resident#1. Interview of the visiting family member indicated neither of the 2 PSW's were wearing a yellow gown while performing toileting of the resident.[s. 229. (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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 28th day of November, 2014

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

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

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Health System Accountability and Performance Division
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 24, 2014	2014_360111_0025	000624, 000221	Complaint

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road 3rd Floor PICKERING ON L1V 1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 1-3, 2014

2 complaint inspections (log# 000221 & 000629) were completed.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the resident, a family member, Physiotherapy Assistant (PTA),Restorative Care Aide (RCA), Registered Nurse(RN), Registered Practical Nurses(RPN), and Personal Support Workers(PSW).

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Reporting and Complaints

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure the written plan of care for Resident #1 was provided related to positioning.

Observation of Resident#1 on a specified date indicated the resident was in bed, and the resident's head was improperly positioned. A small positioning pillow was located on the floor to the right side of the bed. The resident rang the call bell at the inspectors direction and a PSW entered the room, turned off the call bell and proceeded to pick up the pillow that was on the floor and placed the pillow on the residents bed). The PSW repositioned the resident after prompted by the inspector that the resident was improperly positioned and the positioning pillow was not used.

Interview of Resident #1 indicated the resident required pillows for repositioning while in bed and when up in wheelchair due to lack of trunk support.

Review of the care plan (current) for Resident #1 indicated under bed mobility, the resident requires full staff assistance with positioning related to diagnoses. The interventions included:staff to turn and reposition every two hours, and use pillows to aid in positioning and comfort. [s. 6. (7)]

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 the written plan of care is provided to residents related to positioning, to be implemented voluntarily.

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Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system was accessible for Resident#1 use at all times.

Observation of Resident#1 on a specified date for a 4 hour period indicated the call bell was placed in the residents' lap towards the right side, inaccessible to the resident due to weakness. Interview of Resident #1 indicated sometimes they have "to wait a long time for staff to respond to calls". When the call bell was provided to the resident and the resident activated the call bell, a PSW responded in a timely manner. The PSW then clipped the call bell to the residents' right upper thigh area of pants (where the resident could not reach).

Observation and interview of Resident #1 on the following day indicated the resident was up in a mobility aide. The call bell was left on the resident's bed (not accessible to the resident). Interview of a family member (who was visiting the resident at the time) indicated upon arrival, the resident's call bell was not within the residents' reach. [s. 17. (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 the resident-staff communication and response system is accessible to all residents at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Review of the current care plan for Resident #1 indicated the resident is diagnosed with an infectious condition requiring the use of contact precautions to notify visitors and staff of resident's precautions (including staff to wear gown and gloves when providing care and staff to perform hand hygiene after contact with resident, and staff to designate a sling and commode for use).

Interview of the DOC indicated that Resident #1 has a sling that is kept on the back of resident door and a commode designated for use due to diagnosis and is normally stored in the shower room.

Observation of Resident#1 room on a specified date for a 4 hour period indicated there was personal protective equipment (PPE's) (yellow gowns and gloves) available and a contact precautions signage posted directing staff which PPE's to use when performing personal care. The resident's bathroom had an unlabelled denture cup on the counter and this is a shared bathroom. Observation of Resident #1 on the following day indicated there was PPE's available and a contact precautions signage on the door. The resident was up in a mobility aide after being toileted with assistance of two PSW's. One PSW remained in the room to clean the soiled commode. The PSW was observed only wearing gloves and no gown. The PSW then asked the visiting family member to push down on the commode seat seat without the use of any PPE's. The PSW then proceeded to clean the soiled commode in the resident's washroom without wearing a gown as directed on the contact precautions. The commode was left in the shared washroom and was not labelled as designated for use only for Resident#1. Interview of the visiting family member indicated neither of the 2 PSW's were wearing a yellow gown while performing toileting of the resident.[s. 229. (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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 28th day of November, 2014

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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 30, 2015;	2014_280541_0035 (A1)	O-001065-14	Resident Quality Inspection

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road 3rd Floor PICKERING ON L1V 1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

AMBER MOASE (541) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

CO #006 date for compliance amended to February 9, 2015 at request of Long-Term Care Home.

Issued on this 30 day of January 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 30, 2015;	2014_280541_0035 (A1)	O-001065-14	Resident Quality Inspection

Licensee/Titulaire de permis

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

AMBER MOASE (541) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): October 27-31 and November 3-7, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Director of Quality Nursing (DQN), the Environmental Services Manager (ESM), Resident Care Area Managers, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aides, Housekeepers, the Presidents of both Resident and Family Councils, Families and Residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

23 WN(s)
8 VPC(s)
6 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. Related to log #O-000903-14 for Resident #48:

The licensee failed to comply with O.Reg.79/10, s.101 (1)1 by not ensuring that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home:
• has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and

• where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately investigated

The Action Line was contacted on a specified date by Complainant #75 voicing concerns relating to Hot Weather Temperature. The complainant indicated having had contacted the Administrator 6 days prior as to excessive temperatures within the home. The Administrator, during an interview on November 03, 2014, indicated receiving a written (email) complaint from Complainant #75 on a specified date; details of the complaint were as follows:

- Complainant indicated visiting a family member (a resident of the home) on several occasions; while sitting in the dining room assisting resident observed sweat pouring of the faces of kitchen and nursing staff, as well as off the faces of many of the residents. Complainant indicated during the same observation, resident's faces being flushed. The written complaint indicated the temperatures in the dining room were oppressively hot and quite unbearable.

The Administrator provided further email correspondence written by Complainant #75 on three other dates requesting a meeting with the Administrator and Resident Care Area Manager to discuss excessive hot temperatures and other concerns. The Administrator did comment that a meeting with the complainant occurred on a specified date, but agreed the meeting and or communication was twenty days following the initial complaint.

According to the Meeting Minutes, on a specified date, the response provided by the Administrator to the Complainant, surrounding excessive temperature within the home, was 'everything that could be done was being done'.

The Administrator indicated that an investigation relating to complainants concerns was not completed as the home was doing everything possible to control the home's heating and cooling.

The Environmental Services Manager (ESM), on a specified date, indicated no awareness of this complaint with regards to excessive temperatures within the home. [s. 101. (1) 1.]

2. The licensee failed to comply with O. Reg. 79/10, s. 101 (2), as it relates to a verbal complaint made by complainant #76 and Residents #07, 53 and 08 by not ensuring that a documented record is kept in the home that includes:

(a) the nature of each verbal complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

Related to Log #O-001184-14, for Resident #42:

Complainant #76 contacted the ActionLine on a specified date voicing a concern as to the temperature in the home and its effect on complainant's loved one. Family indicated that concerns have been voiced to the Director of Care (DOC) and the home has not done anything about the concern.

The Director of Care indicated that a call was received by Complainant #76 regarding the heat once sometime last month. The DOC indicated a Client Feedback Form had not been completed as the call was not taken as a complaint but a concern. The DOC indicated that the home is sometimes warmer than usual but the heating system is older and difficult to regulate.

The Administrator and Environmental Services Manager indicated no awareness of this family's complaint.

Relating to Residents #07 and #53:

Residents #07 and #53 indicated reporting complaints to the management and or nursing staff, relating to a) their room being cold, especially the washroom and; b) that two residents across the hall cry all night long. Residents indicated these are long standing complaints without resolution. Residents indicated they have stopped voicing concern as their complaints go unheard. It was also noted that the vent in bathroom has been covered with cardboard and masking tape; On a specified date residents indicated staff had covered the vent.

The ESM indicated that Residents #07 and #53 frequently complain of their rooms being cold but when investigated the ESM finds the window open; ESM indicated no awareness of the vent in the room being covered with cardboard and masking tape.

Staff # 102, who works on the resident home area where Resident #07 and #53 resides, indicated being aware of the resident's concerns about the two residents crying or frequently calling out, indicating the (responsive) behaviour is normal for the residents.

The DOC indicated no awareness of the complaints by Resident #07 and #53 re: residents crying all night, but did indicate the concern would be addressed with Resident Care Area Manager.

Relating to Resident #08:

Resident #08 indicated voicing several complaints to the management team during a care conference on a specified date; resident indicated voicing the following complaints, a) the drapes in the resident's room had not been cleaned in over two years, b) when resident rings call bell for assistance, staff enter the room, cancel the call bell and indicate they will get someone to assist; resident indicated staff rarely return; and c) referred to an incident where resident asked for assistance in returning to room and staff shouted I'm busy helping residents on a specified unit, I'm not assigned to your unit, you will need to ask someone else to assist you. A progress note in resident #08's health record indicated that Staff #124 completed a Client Feedback Form following the conference.

The DOC indicated no awareness of Resident #08's concerns which were voiced at the annual care conference held on a specified date, despite Staff #124 indicating in the progress notes that a Client Feedback Form had been completed. Both the Director of Care and Director of Quality had no record to a form being completed. The Director of Quality indicated that Staff #124 can not recall if a form had been completed.

A review of the home's Client Feedback Forms 2014 binder (complaints log) for a 4 month period failed to provide any supporting documentation that the complaints voiced by Resident #07, 08, 53 and Complainant #76 were recorded on the Client Feedback Forms as indicated in the home's policy (Complaint Handling Process, ADM-QUA-100) nor is there any supporting records indicating the management of the home responded to the complainants.

The home's policy, Complaint Handling Process (ADM-QUA-100) directs that a Client Feedback Log is to be completed by any person receiving a concern or complaint. The policy communicates that it is the responsibility of the person receiving a concern

or complaint to document the information on the Client Feedback Log Form, if follow up is required; identifying actions taken or recommended actions and names of persons accountable for these actions. The completed form is to be submitted to the Administrator.

The policy indicates that resident, family and visitor concerns are to be addressed promptly in an efficient manner and that client satisfaction is evidenced.

The Administrator indicated not being aware of any of the above concerns, despite resident's and family indicating concerns were voiced to the management team and asked that inspector addresses these concerns to others on the management team. [s. 101. (2)]

3. The licensee failed to comply with O. Reg. 79/10, s. 101 (3), by not ensuring that complaints received are reviewed and analyzed for trends at least quarterly and that the results of the review and analysis are taken into account in determining what improvements are required in the home.

The Administrator indicated, in an interview on November 03, 2014, that the Admission's Coordinator tracks all complaints and completes trending and analysis; the Administrator indicated that trending and analysis of complaints is completed but was unsure how often and commented complaints are to be reviewed at quarterly Leadership meetings but this has not been consistently occurring over the past year.

The Admission's Coordinator indicated being recently assigned the role of grouping complaints into categories (e.g. communication, lost money, clothing or property, resident issues, food issues, etc.) but indicated the management team has not yet utilized the information to determine trends occurring nor has information been used in determining improvements required in the home. The Admission's Coordinator indicated that this is a new process for the home and has not been completed on a quarterly basis.

The home's policy, Complaint Handling Process-Client Feedback Log (ADM-QUA-100) directs that the Administrator will complete the Client Feedback Log Summary Log on a monthly basis and will provide a summary of all Client Feedback Logs for the previous month to the Leadership/Partnership Team.

The policy further directs that the client feedback summary (monthly) is to be utilized for identifying trends, risk problems, and recommendations. [s. 101. (3)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The following observations were made:

- Staff #117 was observed, on a specified date, cleaning a specified room; staff was observed not wearing personal protective equipment (PPE), despite signage on the door indicating Contact Isolation/Precautions. Staff #117 indicated being told by Registered Nursing Staff that PPE's were not required. It is noted that this is a shared resident room.

- Staff #118 was observed, on a specified date, cleaning room a specified room; staff was observed not wearing personal protective equipment (PPE), despite signage on the door indicating Contact Isolation/Precautions. During this same observation, Staff #118 had the housekeeping cart inside of the room. Staff indicated that the residents residing in the room were not contagious and that PPE's were not required when cleaning the room. It is noted that this is a shared resident room.

- On a specified date, two nursing staff were observed caring for a resident in bed, in a

specified room; staff were not seen wearing personal protective equipment (PPE), despite signage on the indicating Contact Isolation/Precautions.

The home's policy, Isolation - Daily Cleaning (HKG D-10-05) directs that the Housekeeping Aide is to gown and glove at entrance of isolation rooms prior to cleaning.

The ESM indicated that Housekeeping Staff are to wear personal protective equipment (gown, gloves, ect.) at all times when cleaning rooms with signage indicating Contact Precautions /Isolation or any other infection precautionary signs. The DOC and ESM confirmed that the Registered Nursing staff had provided improper direction to the staff regarding the PPE.

The ESM confirmed that both Staff #117 and #118 had annual education specific to infection control, which included cleaning and disinfection and additional precautions / use of PPE's; training was completed May and June 2014.

The DOC, who is the lead for infection control, indicated that staff providing direct resident care and/or housekeeping staff cleaning resident rooms are to wear the indicated PPE when any resident is designated as being in isolation or infection precautions. The DOC further indicated that housekeeping carts are not to be in resident rooms, but are to be in the hallway outside the room.

Other Observations on a specified date:

- Staff #105, who was working Linden Home Area, was observed administering medications during the noon medication pass; staff was observed administering medications to three residents, including once administering insulin without performing hand hygiene before or after any of the three residents.

- Staff #124, who was working Maple Resident Home Area, was observed administering medications during the noon medication pass; staff was observed administering medications to three residents without performing hand hygiene before or after any of the three residents.

The DOC indicated that all staff are provided infection control education upon hire and annually; education includes, 4 Moments of Hand Hygiene. The DOC indicated it is the expectation that all staff perform hand hygiene before and after contact with all residents. [s. 229. (4)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that Residents #8, #15, #30, #29, #42, #16, #50, #57, #55 are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Emotional Abuse Definition
Under O.Reg.79/10, s.2(1)(a) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Related to Resident #8
During stage one of the RQI:
-Interview of Resident #8 (by Inspector # 554) stated they "had a confrontation with a staff member, and at the time, I hurt my arm, had to use manual chair, and they left me in the dining room. I asked staff member "Can you take me back? I had to ask several times". Staff responded "I'm looking after Maple not Birch, get someone else."
Review of the progress notes for Resident #8 indicated during the care conference on a specified date, the home was notified of the resident's concern of neglect of care

and indicated a "client feedback form was completed" at that time. There was no documented evidence a "client feedback form" was completed at that time or an investigation into the allegation completed. A "Client Feedback" form was provided to the inspector by the DQN indicating Resident #8 had been re-interviewed and identified the staff member involved in the allegation of staff to resident neglect as PSW #136 but the staff member had not yet been interviewed. Review of the staff schedule for PSW#136 indicated the PSW worked 6 evening shifts since the home becoming aware of the incident.

Review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures states:
- If an employee(s) is involved, immediately notify of the pending investigation requiring alleviation from duty pending completion of the investigation, including reporting requirements to the Director (MOHLTC) and local police authorities.
- Immediately remove the persons allegedly or suspected of inflicting abuse from the immediate area and any resident home area, pending further investigation
-the Registered staff will report the alleged, actual, or suspected abuse to the Administrator, General Manager, Director of Care, Wellness Coordinator, and or designate, local police authorities, and the Director (MOHLTC).
- registered nursing staff and the person discovering the abuse shall prepare a written incident report. The report shall include: what occurred, when it occurred, who was involved, names of witnesses, where it occurred, what was observed and heard. The report shall be submitted to the Administrator, Director of Care and or designate.

Related to Resident #29
- Resident #29 stated during an interview on a specified date that "I had an earache and reported it to the RPN who told me the doctor would be in tomorrow to assess. The following day I saw the physician but he did not come to see me. A week later, the physician came in to see me and I stated I still have the earache and the physician said very loudly and abruptly to me "do you realize people die here". I just wanted my ear ache dealt with but I didn't like that." On a specified date the Administrator was notified of the allegation of physician to resident emotional abuse towards Resident #29. Review of the homes investigation indicated on a "client feedback log", dated the day the home became aware of the incident, the resident was interviewed and confirmed what was reported to the inspector. The form indicated under further action: "speak to Dr." to be completed by Administrator and DOC. There was no indication the physician was interviewed as of 7 days later and the physician had been in the home on 4 occasions since the home becoming aware of the incident.

There was no documented evidence that when the allegations of staff to resident abuse/neglect for Residents #8 and #29 were reported to the Administrator on the dates specified, that the Administrator completed the resident incident report as indicated in the home's policy as "the person discovering the abuse". The progress notes and plan of care were not updated regarding the allegations, as well as interventions to prevent recurrence and no indication that the substitute decision makers of the residents were notified of the allegations.

Review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures states:
- registered nursing staff and the person discovering the abuse shall prepare a written incident report. The report shall include: what occurred, when it occurred, who was involved, names of witnesses, where it occurred, what was observed and heard. The report shall be submitted to the Administrator, Director of Care and or designate.
- Immediately remove the persons allegedly or suspected of inflicting abuse from the immediate area and any resident home area, pending further investigation
-the Registered staff will immediately notify the Resident's substitute decision maker, if any and any other person specified by the Resident, and they are to be notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a Resident

The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA, 2007 s. 23.(1)a Every licensee of a long-term care home shall ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff (Refer to WN#16)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

Verbal Abuse Definiton
Under O.Reg.79/10, s.2(1) (a) defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense

of well-being, dignity or self-worth, that is made by anyone other than a resident.

Related to Resident #15
-Interview of Resident #15 on a specified date "a staff member yells at him/her and is rude". The Administrator was notified of the allegation on October 30, 2014. The DQN indicated becoming aware of the allegation of staff to resident abuse on approximately 3 days later and initiated the investigation 2 days afterwards using the "client feedback forms". The DQN was not aware a "Resident Incident Report" was to be completed for allegations of abuse instead of a "Client Feedback Form". Review of the "client feedback form" provided by the DQN on a specified date indicated that PSW #134 was the alleged staff member involved in the incident and was to be interviewed by the DOC. The DQN indicated only the resident had been interviewed regarding the allegations. There was no indication that any of the staff had been interviewed or notified of the allegation or any other actions taken 4 days after the allegation was reported to the home by the Inspector. Review of the staff schedule indicated that PSW#134 had worked day shift on three occasions since the home becoming aware of the incident.

Review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- Immediately remove the persons allegedly or suspected of inflicting abuse from the immediate area and any resident home area, pending further investigation.
-The Registered Staff and the person discovering the abuse shall prepare a written incident report. All documentation of an alleged, actual, or suspected abuse incident will use descriptive and precise language free from opinion and conjecture. The report shall contain the following information and shall be submitted to the Administrator, General Manager, Director of Care, Wellness Coordinator and/or designate: what occurred, when it occurred, who was involved (including the names of witnesses or those who were in the vicinity when it occurred), what was observed/heard, written statements from witnesses including information pertaining to the incident.
-the Registered staff will immediately notify the Resident's substitute decision maker, if any and any other person specified by the Resident, and they are to be notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a Resident.
The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)

- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

Related to Resident #30
-Interview of Resident #30 stated "a couple of weeks ago, a staff member was yelling at me in the morning when they were washing my face but I don't know their name". On a specified date the Administrator was notified of the allegation of staff to resident verbal abuse towards Resident #30. Review of the health care records for Resident #30 had no documented evidence that the SDM, or any other person specified by the resident were notified of an alleged incident of verbal abuse. Review of the "Client Feedback" form provided by the DQN indicated 5 days after the home becoming aware of the incident, the resident was interviewed by the DQN and indicated PSW #137 was the staff member allegedly involved in staff to resident verbal abuse. The form indicated staff member had not yet been interviewed regarding the allegation. Review of the PSW schedule indicated that PSW #137 worked day shift on 5 occasions since the home becoming aware of the incident.

Review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- Immediately remove the persons allegedly or suspected of inflicting abuse from the immediate area and any resident home area, pending further investigation.
-The Registered staff will immediately notify the Resident's substitute decision maker, if any and any other person specified by the Resident, and they are to be notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a Resident.
The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

There was no documented evidence that when the allegations of staff to resident abuse/neglect for Residents #15 and #30 that were reported to the Administrator on

specified dates, that the Administrator completed the resident incident report as indicated in the home's policy as "the person discovering the abuse" . The progress notes and plan of care were not updated regarding the allegations, as well as interventions to prevent recurrence and no indication that the substitute decision makers of the residents were notified of the allegations.

Related to Resident #16:
The home's former Director of Care, submitted a Critical Incident Report on a specified date. The CI details an incident of Staff to Resident (verbal) abuse, which was said to have occurred 2 days earlier; details of the incident are as follows:
- Staff #119 was asked by Resident #16 to make resident's bed; Resident #16 called staff 'a lazy bitch'. Staff #119 responded 'I'm not a bitch, you are the bitch'.
The allegation of Staff to Resident (verbal) abuse was reported by the Registered Practical Nurse (#124) to the Resident Care Area Manager (RCAM #123), who was the supervisor in the home during the incident which occurred.
According to the CI report, the RCAM contacted the Director of Care of the incident. The incident of Staff to Resident Verbal Abuse was not reported to the Director within the time line required under legislation.

A review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- the Administrator, Director of Care and or designate will immediately report the incident to the Director (MOHLTC) and local police authorities.

The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA 2007 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: 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. (Refer to WN #17)

Related to Log #O-000584-14 for Resident #50
A critical incident, submitted, by the home's former Director of Care, on a specified date describes an incident of alleged Staff to Resident (verbal/physical) abuse reported to have occurred 1 day earlier.

Details of the CI are as follows: According to a Critical Incident Report Resident #52 reported hearing a staff member yelling at Resident #50 in the hallway sometime during the night; Resident #52 reports hearing staff yell at Resident #50 to go back to bed and then reports hearing a slapping sound followed by a yelping sound from Resident #50. According to the CI report, Resident #52 reported the incident to family; in turn, Resident #52's family reported the incident of verbal/physical abuse to Resident Care Area Manager (RCAM #123).

Director of Care indicated that Resident #52 has since deceased but was cognitively well when the incident was reported.
The current DOC indicated that there were three staff (a Registered Practical Nurse and two Personal Support Workers) assigned to work the night shift, on Resident #50 and #52's home area, on the date in question. The DOC indicated not being involved with the staff interviews, and deferred further comments to the Director of Quality Nursing (DQN). The DQN stated that he and the former Director of Nursing interviewed the three staff as to the allegation of Abuse; Director of Quality indicated Staff #120, 121 and #122 were not interviewed as to the allegations until 7 and 8 days after becoming aware of the incident.
A review of the home's Staffing Assignment Schedule for a specified period, indicated that Staff #120, 121 and #122 worked shifts following the allegation and prior to being interviewed by the licensee or its designate on dates indicated above.

The Director of Quality could not comment as to why there was a delay in investigating the incident of alleged Staff to Resident Abuse. The Director of Quality commented the investigation as to the allegation of abuse was completed on a specified date and findings were inconclusive.
The Director of Quality indicated that the practice of the home is to immediately investigate all allegations of suspected or witness abuse and that during the investigation, staff alleged to be involved are normally placed on a leave of absence pending the outcome of the investigation.
The DOC and Director of Quality both indicated the allegation of abuse (verbal/physical) was not reported to the police. The Director of Quality, who was present during the investigation of the abuse, indicated the incident was not reported to the police as Resident #50 was assessed by registered nursing staff and found to have had no visible injuries nor could resident recall the incident.

A review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- Immediately remove the persons allegedly or suspected of inflicting abuse from the

immediate area and any resident home area, pending further investigation.
The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- O. Reg 79/10 r. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98 (Refer to WN #23)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

Related to Resident #42
Complainant #76 contacted the home on a specified date and time, to report that Resident #42 had asked a staff member to turn off the television, as remote control was not within resident's reach; complainant indicated that a staff member stated, to the resident, "I'm not your bloody slave". Complainant indicated being concerned as to the way his/her loved one is being treated in the home when family is not around.
Resident #42, during an interview on a specified date, indicated feeling belittled by the comment of staff; resident further commented 'I can't wait to get out of this place'.
Complainant #76 stated the concern surrounding verbal abuse was brought to the attention of Registered Practical Nurse #148, who was the Charge Nurse, working on Resident Home Area that day.
Staff #148 commented during an interview on a specified date, that the allegation of verbal abuse was brought to the attention of the Registered Nurse Supervisor, who was in charge of the home, on the date of the incident.
Staff #148 indicated that MOHLTC was not contacted as to the allegation of verbal abuse, as that is not staff's role, but a supervisor's job.

Resident Care Area Manager (#145) indicated awareness of the allegation but commented such was not reported to Director. The DOC indicated no awareness of Complainant #76's allegation of verbal abuse. The Administrator indicated that all staff are to report allegations of Abuse. The RCAM #145 stated during an interview on a specified date that the resident was not spoken to following the incident. Staff #148, RN supervisor and RCAM #145 all indicated they did not contact the resident's substitute decision maker following becoming aware of the incident. Staff #148 spoke

with only two of the three staff working on the day of the incident.

A review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- If an employee(s) is involved, immediately notify of the pending investigation requiring alleviation from duty pending completion of the investigation, including reporting requirements to the Director (MOHLTC) and local police authorities.
-The Registered Staff and the person discovering the abuse shall prepare a written incident report. All documentation of an alleged, actual, or suspected abuse incident will use descriptive and precise language free from opinion and conjecture. The report shall contain the following information and shall be submitted to the Administrator, General Manager, Director of Care, Wellness Coordinator and/or designate: what occurred, when it occurred, who was involved (including the names of witnesses or those who were in the vicinity when it occurred), what was observed/heard, written statements from witnesses including information pertaining to the incident.
-the Registered staff will immediately notify the Resident's substitute decision maker, if any and any other person specified by the Resident, and they are to be notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a Resident.
The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA 2007 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: 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. (Refer to WN #17)
As of November 6, 2014, the Director of Care was investigating the concern of Complainant #76.

O.Reg. 79/10, s.2(1)(b) defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or staff member.

Log #00051 related to resident #57:
Review of the progress notes for Resident #54 indicated:
-on a specified date Resident #54 was found in his/her room with door closed and

Resident #57 in the room. Staff removed Resident #57 from the room and Resident #54 followed them out of the room as well. Resident #54 then sat with Resident #57 at the nursing station and was observed with "his/her hands on Resident #57's private area and when the PSW attempted to separate them the resident hit the PSW on the hand" Resident #57 was taken to his/her room. Interview of the DOC indicated the incident was not reported to the Director.
Review of the current care plan for Resident #54 indicated the resident is diagnosed with Dementia, is independently mobile, and demonstrates specified responsive behaviors. Strategies to deal with the responsive behaviors are specified in the care plan.

The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA 2007 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: 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. (Refer to WN #17)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

Related to Resident #55
A Critical Incident Report (CIR) was submitted by the home on a specified date for a resident to resident sexual abuse incident that occurred on a specified date. The CIR indicated Resident #55 was seen walking with a PSW towards own room and "was crying uncontrollably". When CN ask resident why the resident was crying, the resident stated that Resident #54 was sitting on a chair across from him/her at the nursing station when Resident #54 reached over and placed his/her hand between the resident's legs, touching his/her private area and then touched his/her self. The CIR had no indication that police were called.
Review of the progress notes for Resident #54 from a specified date range indicated:
-on a specified date the resident was observed “displaying inappropriate sexual behaviour towards another resident”. The PSW observed the resident inappropriately touch another resident. There was no indication which resident and no documented

evidence of an investigation.
-on a specified date staff overheard voices in the residents room and when entered the room, found another resident laying in the resident's bed. The resident was distracted while staff removed the other resident from the room. There was no incident report completed and no indication who the other resident was.
-on a specified date the resident was found in his/her room with door closed and Resident #57 in the room. Staff removed Resident #57 from the room. The resident followed them out of the room and then sat with Resident #57 near nursing station. The resident was then observed inappropriately touching Resident #57 and when the PSW attempted to separate them the resident hit the PSW on the hand" Resident #57 was taken to his/her room. The POA of resident was not notified of incident.

Review of the homes investigations and interview of staff indicated there was no investigations completed related to witnessed or suspected incidents of sexual abuse that occurred on the identified dates.
Review of the progress notes for Resident #55 and Resident #54 on a specified date had no indication the police were notified. Interview of the DOC indicated that if it was not indicated on the CIR then they were not notified.

The licensee failed to comply with:
- O. Reg 79/10 r. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98 (Refer to WN #23)
- LTCHA, 2007 s. 23.(1)a Every licensee of a long-term care home shall ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff (Refer to WN #16)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

In addition to the individual incidents and the areas of non-compliance identified for the incidents involving Residents #8, #29, #15, #30, #16, #50, #42, #57, #55, the following was also identified:

The licensee failed to comply with O. Reg. 79/10, s. 101(2), as it relates to a verbal complaint made by complainant #8 by not ensuring that a documented record is kept

in the home that includes:
(a) the nature of each verbal complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant (As identified in WN #1)

The licensee failed to comply with LTCHA, 2007, s. 76(4), by not ensuring that all staff have received retraining annually relating to the following:
• The Residents' Bill of Rights
• The home's policy to promote zero tolerance of abuse and neglect of residents
• The duty to make mandatory reports under section 24
• The whistle-blowing protections (As identified in WN #19)

The licensee has failed to comply with O. Reg 79/10 s. 96. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, (d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation. (As identified in WN #21) [s. 19. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:
1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount. 2007, c. 8, s. 91 (1).
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Findings/Faits saillants :

Related to Log #000146:

The licensee has failed to ensure that residents in preferred accommodation are not charged more than what can be charged for basic accommodation unless the preferred accommodation was provided under an agreement.

A complaint was received from the SDM of Resident #44 indicating on a specified date in 2012 the resident was transferred from a semi-private room to a private room and the SDM was not made aware of the transfer until after the resident was transferred. A review of the progress notes from a specified date range in 2012 for Resident #44 indicated the resident was transferred from one unit on a specified date in 2012 to another unit and there was no indication the SDM was notified.

The complaint submitted by the SDM of Resident #44 also indicated being overcharged for accommodations at a rate that was not agreed to in the admission agreement. Review of Resident #44's admission agreement indicated the resident was admitted into semi-private accommodation room/rate on a specified date in 2010. There were no other accommodation agreements in place.

Review of the resident's charges for accommodation indicated the resident was admitted on a specified date in 2010 at semi-private rate. The resident remained on semi-private rate (along with annual increases in July of each year) until a specified date in 2012 when the monthly accommodation charge was increased to private accommodation rate. The private rate was charged until a specified date in 2014 when the accommodation charge was changed to a basic accommodation rate. The SDM requested the funds be reimbursed.

Interview of the Administrative Assistant (AA) indicated she was given verbal direction by the previous DOC during a specific month of 2012 to change Resident #44's accommodation rate from semi-private to private rate as the resident was moved to a private room from a semi-private room. The AA indicated she did not complete a new accommodation agreement or contact the family regarding the new rate change. The AA indicated on a specified date in 2014 she received an email from the Administrator that the resident's rate was to be reduced to basic rate and the accommodation rate was changed. [s. 91. (1) 2.]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

Related to Log #O-001255-13

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

A Critical Incident indicated that on a specified date PSW #128 was getting Resident #46 dressed out of bed for lunch. Resident was sitting upright at side of bed. PSW #128 turned around to get wheelchair and Resident #46 fell forward onto the floor sustaining an injury that required sutures at hospital.

Review of Resident #46's plan of care related to transferring and Falls/Balance indicated the resident requires extensive assistance – two + persons physical assist and the resident's risk of falls is high related to history of falls, unsteadiness, and self transferring but too weak to do so.

Resident #46's progress notes were reviewed. On a specified date, RPN #131 documented that Resident #46 fell from bed and sustained an injury. The resident was unconscious for a few minutes.

On a specified date, interview with PSW #128 indicated at the time of the incident, PSW#128 assisted Resident #46 to dress up and sat him/her up at edge of bed. Resident's feet at the time were not entirely flat on the floor. PSW #128 was aware of resident's transfer status of 2 persons assist and was waiting for another staff member to help. The resident fell, while PSW #128 was reaching over to pull the wheelchair and could not prevent the resident from falling.

On a specified date, interview with DOC indicated at the time of the incident, a bang was heard from Resident #46's room and found Resident #46 on the floor. The DOC indicated that PSW #128 should have not left Resident #46 sitting at edge of bed as the resident could not maintain upright sitting position and requires two persons assist for transfer.

An internal investigation completed by the home confirmed that PSW #128 had failed to use safe transferring techniques when the resident was left sitting at the edge of bed, unsupported. [s. 36.]

Related to Log #O-000500-14

The licensee has failed to ensure that staff use safe transferring techniques when assisting residents

A Critical Incident indicated that on a specified date while PSW #127 and PSW #110 were transferring Resident #46 from bed to wheelchair using a mechanical lift, the resident fell out of the sling onto the floor approximately 4 feet to the ground, sustaining an injury.

Resident #46's progress notes were reviewed. On the date of the incident, RPN #124 documented that PSWs on Pine unit were transferring Resident #46 from the bed to the wheelchair using a mechanical lift. During the transfer, Resident # 46 fell from the sling and sustained a skin tear. Sling used for transfer was blue with red boarder (Arjohuntleigh Article Num MAA4100m-s). No visible deficit was noted on sling all four clips were present and intact.

On a specified date interview with PSW #127 indicated at the time of incident the left hook snapped and had no idea how that happened. PSW #127 was operating the lift when PSW #110 was coming around. The hook was not broken, it was just snapped. PSW #127 stated "I should pay more attention".
On November 6, 2014 interview with PSW #110 indicated at time of incident he/she was assisting staff #127 to transfer Resident #46. PSW #110 hooked up the left side and checked it and PSW #127 hooked up the other side. While Resident #46 was lifted, the left hook came off causing the resident to slide down and roll to the floor. PSW #110 was not guiding the resident when the resident fell. PSW #110 was coming around to direct the resident to the chair.

A written statement by PSW #110 on the date of the incident indicated that while helping a staff member to transfer Resident #46 from the bed to the wheelchair, the resident slid out of the sling onto the floor.

A written statement by PSW #127 on the date of the incident indicated that while getting Resident #46 up from bed with my partner, we used the full lift that we were supposed to use. When lifting the resident up, the sling at the left side snapped and the resident slid out of the sling and fell.

An interview with DOC on a specified date indicated that, she was called to unit and found Resident # 46 on the floor. The DOC confirmed that PSW #127 and PSW #110 did not follow policy of operating the mechanical lift to ensure the resident is safe during the transfer. One PSW forgot to clip his/her side of the sling and the other PSW started to operate the lift while his/her partner was not ready to guide and reassure the resident during the transfer.

An internal investigation completed on a specified date by the home concluded that PSW #127 and PSW #110 had performed an improper mechanical lift which resulted in injury to resident.

The staff failed to ensure the Resident's safety during transfer. [s. 36.]

Related to Log #O-001202-14

The licensee has failed to ensure that staff use safe transferring devices or techniques when assisting residents.

Resident #49's progress notes were reviewed. On a specified date, RPN #141 documented that 2 staff were transferring Resident #49 from bed to wheelchair by a full mechanical lift (ergo). During the transfer, the resident was on the sling up in the air over the wheelchair and the mechanical lift tilted entirely with the sling backward. The resident was over the wheelchair and landed on it, no injury was noted. Resident Care Manager (RCAM) and maintenance were notified and the lift was taken to be repaired.

On November 6, 2014 interview with RPN #141 indicated that on the date of the incident, two PSWs were transferring Resident #49 from bed to wheelchair when the whole lift tilted entirely backwards with the resident. The lift had a defect or a problem and could not tell what was wrong with the lift. RPN #141 indicated that the

expectation is that PSWs should have checked the lift before use. An out of order sign was placed on the lift after the incident.

During an interview with PSWs #108, #142 and #143 they indicated that lifts are checked if working properly before use. The lifts are checked for charged batteries, proper sling, make sure the lift is clean, check arms if moving up and down and legs moving in and out, check if lift is easy to move, check sling is clean and not damaged. If a problem noted the nurse is informed, requisition is completed on computer and out of order sign will be placed on lift.

On a specified date and time, interview with Environmental Services Manager (ESM) indicated that lifts are inspected on monthly basis for preventative maintenance. The lifts are checked for the up and down and legs for out and close. If the lift is defective it will be removed for repair.

Review of a note by maintenance staff #144 indicated that an Ergo lift was tagged out of service and removed for inspection by maintenance on the date of the incident, after the incident occurred. A note by ESM indicated that the lift was tagged out in the maintenance shop from the date of the incident and a request for inspection was sent to Arjohuntleigh 15 days later.

Review of Arjohuntleigh service call report indicated the Ergo lift Maple #3 serial number ERLI-1887 which was used on the date of the incident, was inspected and found that the legs were loose and not aligned properly. The lift was repaired and technician suggested the some parts of the lift to be replaced including: 1 braked caster, emergency stop switch, hanger bar cover and pin assembly. The recommended parts were replaced.

There is no documented evidence that the Ergo lift Maple #3 serial number ERLI-1887 was inspected to be in good repair and safe for use prior to the incident by maintenance staff or by PSW staff prior to use with Resident #49. There was no maintenance record of this lift prior to the date of the incident and there was no documentation the lift was checked monthly similar to other lifts in the home as it was not included in the assets inventory of the home. [s. 36.]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 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 :

Related to Log #000551:

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

Review of the current care plan for Resident #54 indicated the resident is diagnosed with cognitive impairment, is independently mobile, and demonstrates specified responsive behaviours and specified strategies to manage the responsive behavior.

Review of the progress notes over a 6 month period for Resident #54 indicated on specified dates and times 4 incidents where Resident #54 inappropriately touched another resident, 2 incidents where another resident was found in Resident #54's room without staff being aware, 3 incidents where Resident #54 attempted to hit or touch another resident but was stopped by staff. On one specified date Resident #54's monitoring was decreased from every 15 minutes to every 1 hour monitoring.

Interview of PSW #140 by Inspector #541 indicated that they are not currently monitoring Resident #54 as "his/her behaviours have calmed down". Observation of the resident's room by Inspector #541 indicated the specified interventions in Resident #54's care plan were not in place.

Review of the progress notes for Resident #54 indicated the resident demonstrated inappropriate sexually touching and sexual comments to several residents and staff. The resident also wandered into other resident's rooms and other residents wandering into the resident's room. The resident also displayed verbal and physical aggression towards staff and residents. The resident was placed on every 15 minute checks following the second incident of resident to resident sexual abuse.

The current care plan for Resident #54 indicated that some of the specified strategies suggested were not effective, but still in use and some of the specified strategies were not consistently implemented. Some of the specified strategies identified were not clear as to when they would be implemented. Some of the specified strategies to prevent sexually inappropriate responsive behaviour were not implemented. [s. 53. (4) (b)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 006

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

Specifically failed to comply with the following:

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to privacy was respected and promoted in caring for his or her personal needs.

On a specified date(while walking by), Resident #41 was observed lying in bed with pants pulled down to knees exposing the resident's genitals. The door was completely open and no curtains pulled for privacy.
Interview of RPN #100 who was passing by indicated PSW #101 had left the resident prepped for the RPN to complete a catheter treatment. The RPN entered the resident room and informed the resident that the door would be closed until the RPN could return for privacy. [s. 3. (1) 8.]

2. The following was observed:

- On a specified date and time, a nursing staff member was observed providing incontinence care to Resident #03 in the washroom, the door to the washroom was open; this is a shared (ward) room. During this same observation, another resident was lying in a bed within the room and was able to visualize the washroom and care being provided to Resident #03.

- On a specified date and time, two nursing staff were observed providing care to Resident #42; the door to the room was open to the hallway.

The Director of Care indicated that the expectation is that when care is being provided the privacy and dignity of each resident is to be maintained. The DOC indicated that annual education is provided to all staff with respect to Resident's Bill of Rights. [s. 3. (1) 8.]

3. The licensee failed to ensure the residents right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

Observation of medication pass on Linden unit with RPN #132 indicated after the medications were prepared, the medication packages were tossed in the garbage bin without personal health information altered or removed. Observation of medication pass on Birch unit and interview of RPN #124 indicated that the medication packages are tossed in the regular garbage bin without personal health information altered or removed. [s. 3. (1) 11.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's right to privacy is respected and promoted in caring for his or her personal needs; to ensure the residents right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act and to ensure that the resident's right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care related to internal transfers.

A complaint was received from the SDM of Resident #44 indicating on a specified

date in 2012 the resident was transferred from a semi-private room to a private room and SDM was not made aware of the transfer until after the resident was transferred.

Review of the progress notes from a specific date range in 2012 for Resident #44 indicated the resident was transferred from one unit on a specified date in 2012 the Resident was transferred to another unit and there was no indication the SDM was notified. [s. 6. (5)]

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

Log # O-000075-14:

A Critical Incident indicated that on a date in 2014 Resident #48 was found on floor in his/her room bedside. The resident was assessed and sent to the Hospital where a fracture was confirmed. Resident #48 has high-low bed, bed and chair alarms. At the time of this fall, the alarm was not attached to resident. Falls mat was not on floor beside bed.

Review of Resident #48's plan of care related to Transferring, Falls/Balance and Aids to Daily Living indicated that the resident is at high risk of falling. The plan of care direct staff to:
- Transfer with one person when calm and two person assist when agitated.
- Use bed/chair alarm as resident may attempt to self transfer.
- Keep bed in lowest position, rail down.
- Fall mat on floor beside bed.

Review of progress notes and fall incident report related to Resident #48's fall on a specified date in 2014 indicated that:
- Resident #48 was transferring at time of fall.
- Alarm was not attached to resident. The alarm was attached to the bed.
- Falls mat was not beside the bed. The fall mat was kept behind dresser.

On November 4, 2014 interview with RPN #129 indicated that Resident #48 is at high risk of falling. Interventions in place for Resident #48 to prevent falls include close monitoring, use of alarm in wheelchair, use of bed alarm, bed in lowest position.

On November 4, 2014, interview with DOC indicated that at the time of the incident staff did not follow the plan of care for Resident #48 where an alarm was not attached

to the resident and falls mat was not placed at bedside while the resident was in bed. [s. 6. (7)]

3. Related to Log #O-001171014 for Resident #42:

The licensee failed to comply with LTCHA, 2007, s. 6 (7), by ensuring that the care set out in the plan of care is provided to the resident as specified in the plan.

Complainant #76 contacted the ActionLine on a specified date indicating Resident #42's call bell is rarely in reach. Complainant indicated, during an interview, that resident calls the family almost daily to report call bell and other personal items.

The current written care plan for Resident #42, indicates the following:

Toileting / Continence Care:
- ensure call bell in reach
- do not leave unattended on the toilet

Falls Risk:
- ensure call bell in reach
- commonly used articles are to be within reach

Aids to Daily Living:
- ensure call bell, table and other personal items are within resident's reach at all times

The following observations were made on specified dates and times:
- over bed table containing drinking bottles was observed in front of the closet door; resident was in bed (table was out of resident's reach)
- resident was in washroom using the toilet, door was ajar, and call bell was not in reach of the resident; no staff were in attendance

Resident #42 indicated in an interview on specified dates that the call bell is often not within reach and as a result needs to call family to contact the home to ask staff to come to room to assist. Resident commented that staff do not remain in room when resident is on the toilet and further commented that when the call bell is rung to get off the toilet that staff takes a long time to respond.

Staff #146, who works on the care unit where Resident #42 resides, indicated being

unsure if resident is to be left alone on the toilet or not and was unsure of what personal items were to be within resident's reach; staff indicated not being the primary care provider for this resident.

Resident Care Area Manager (#145) indicated that staff are to respond to call bells as quickly as possible; RCAM indicated that Resident #42's television remote, drinking bottles are to be within resident's reach but stated 'sometimes people forget'.

Director of Care indicated that staff working resident home area's should be aware of resident care needs. [s. 6. (7)]

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

Resident #13 was observed on a specified date by Inspector #554 to be sitting in a wheelchair which was tilted. two specified dates Resident #13 was observed by Inspector #541 sitting in a wheelchair which was tilted.

PSW staff members #S113 and #S115 as well as RPN staff member #S114 stated Resident #13's wheelchair is tilted for comfort and is not used as a restraint. Staff member #S115 stated this information would be found in the resident's care plan. Resident #13's care plan was reviewed and there is no indication that the resident's wheelchair is to be tilted. Staff member #S116 stated that the Occupational Therapist (OT) would determine if the resident's wheelchair was to be tilted. After a review of Resident #13's progress notes staff member #S116 confirmed there was no documentation by the OT to reflect why the wheelchair for Resident #13 is tilted.

The plan of care for Resident #13 failed to specify the reported need for the wheelchair to be tilted. [s. 6. (7)]

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 the plan of care for Resident #13, #48 and #42 is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #9: 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 failed to comply with LTCHA, 2007, s. 15(2)(a), by not ensuring that the home, furnishings and equipment are kept clean and sanitary.

The following observations were from October 27-31, 2014:

- Toilets: dark brownish black staining was visible at the base of the toilet bowl, along the sealant and on the flooring surrounding the toilet in resident washrooms in the following home areas - Birch Unit: # B5, B9, B18, B23, B24; Linden Unit: # L4, L7, L10, L16, L19; Maple Unit: #M1, M3; Pine Unit: # P9, P11

- Flooring: dark brownish black staining, dust and or debris was visible on flooring in resident rooms and/or resident washrooms in the following home areas - Linden Unit: #L4, L7, L9, L10, L16, L17, L19; Birch #B9, B23, B24; Maple Unit: #M1, M3, M6, M14; Cedar Unit #C8; Pine Unit: #P9, P11; the brownish black staining or debris was easily removable when scraped.

- Windows: visible cobwebs, dead bugs and white staining was seen on windows or on window sills in the following home areas - Linden Unit: #L7, L10; Birch Unit: #B4,

B5, Birch Hall (end window) and Maple Lounge

- Shower Stall: Birch/Maple Spa Room – yellowish/brown staining along shower wall tiles

- Tub (ARJO): Birch/Maple Spa Room was observed on October 27-28, 2014 to be visibly soiled with brownish specs of debris and hair; the inside surface of the tub was dry on both occasions. Personal Support Worker(s) indicated that this tub is used on a daily basis for resident care.

- Shower Chair(s): seat of chairs(2) had whitish film visible on seating area of chairs

- Privacy Curtains: soiled in Linden Unit room #L17

Staff #118 indicated that the dark staining on the floors was wax build up and that housekeeping staff did not have time to scrap floors during routine daily cleaning.

Staff #117 indicated that a thorough cleaning of the toilets inside and out are completed as part of the daily cleaning as well as both the resident rooms and washrooms are dry and wet cleaned daily.

The ESM indicated no awareness of the build-up of dust, debris and/or wax on flooring in hallways or in resident rooms. The ESM indicated there is a procedure in place to remove build up on flooring and housekeeping staff should be routinely cleaning these areas. The ESM further indicated that the windows in the home are cleaned by an external contracted service bi-annually and on an as-needed basis by housekeeping staff when observed to need cleaning.

The ESM indicated that there is an expectation that the home is kept clean and sanitary at all times.

Note: Several of the identified resident rooms above had signage on the door indicating contact isolation and/or precautions are in place due to resident(s) identified as having a antimicrobial resistant organism. [s. 15. (2) (a)]

2. The licensee failed to comply with LTCHA, 2007, s.15 (2)(c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following was observed:

- Flooring: was lifting, had seams split or visibly torn in the following home areas - Birch Unit: #B20; Linden Unit: #L4, L7, L19; Maple Unit: #M14 and in common areas on Maple (flooring overlooking atrium), Birch/Cedar foyer area (two areas), Birch – in front of the nursing station

- Walls in resident rooms and/or washrooms: scuffed (black marks), paint chipped, dry wall compound visible or damage seen in the following home areas - Linden Unit: #L9. L16, L17, L19; Maple Unit: #M1, M3, M6; Birch Unit: #B9, B14, B18, B23

- Walls in common areas: scuffed (black marks), paint chipped, dry wall compound visible or damage seen in hallways in Resident Home Areas on Maple (specifically outside of #M17) , Linden, Birch(outside of tub room door and inside foyer as you enter the room) / in tub room on Linden (ceiling, areas of steel encasement exposed)

- Wall Guard: loose or missing in Linden Unit: #L10, L16, L19; Birch Unit #B14

- Closet Doors: scuffed (black marks), bent, off track or doors missing in Linden Unit: #L4, L9, L10, L17, L19; Birch Unit: #B5; Maple Unit: #M1, M3

- Washroom Door: wooden door has a hole in Birch Unit: #B23

- Bed Rails: paint chipped in Linden Unit: #L9; Birch Unit:#B23

- Wall Phone Jack: has no cover in Birch Unit: #B23; Maple Unit: #M6; and Cedar Unit: #C6

- Ceiling: cracked and/or having visible water staining in the following areas – outside of Birch Lounge, inside of Birch Lounge, outside of rooms on Maple Unit: #M7; Linden Unit: #L12

- Door Frames: scuffed (black marks), paint chipped or visible damage in room(s) on Linden Unit: #L7, L9; Birch Unit: #B9, B18; Maple Unit: #M1, M3, M6; Pine Unit: #P9, P11

- Window Screens: loose or bent in on Maple Unit: #M3; Linden lounge

- Window Screens missing in room on Birch Unit: #B24; Maple Unit #M1

- Window 'foggy': Birch Unit: #B5, B24

- Towel Rack: missing, or broken in room(s) on Birch Unit: #B9; Pine Unit: #P25

- Over the Toilet Hand Rails: rusted, paint chipped, foam arms torn or visible damaged in rooms on Linden Unit: #L4, L7, L9

- Washroom vanity laminate: chipped in rooms on Linden Unit: #L9, L17; Maple Unit: #M3; Birch Unit #B23 (note: damaged areas are porous in nature, and pose an infection control risk)

- Bedside Tables or Dressers: laminate surface is chipped or damaged in rooms on Birch Unit: # B23 (note: damaged areas are porous in nature, and pose and infection control risk)

- Shower Hand Rails: rusted in one shower stall in the Maple/Birch Spa Room

- Nursing Stations: laminate surrounding desk area is chipped or damage on Resident Home Area Units – Maple and Linden (note: damaged areas are porous and pose an infection control risk)

- Bathroom Vent: covered with cardboard and masking tape – Linden Unit: #L17

Staff #133, 134 and 135 all indicated being aware of the home's policy regarding communicating to maintenance if repairs and or damage is observed in resident rooms and/or throughout the home; staff indicated that the maintenance requisitions are completed on-line through PM Works and through this system go directly to the ESM. Staff #133 indicated 'urgent' issues are called directly to ESM.

Environmental Services Manager (ESM) reviewed the PM Works system for the period of September 01, through to October 31, 2014 and indicated that there were over 700 maintenance requisitions for home maintenance and/or repairs forwarded by staff. A random sampling of PM Works was conducted (together with ESM and Inspector) and failed to identify maintenance deficiencies in rooms on Birch Unit #20, 23; Linden Unit #16, 17, 19; flooring issues (lifting, or torn areas).

The ESM communicated that PM Works (home's maintenance repair system) is reviewed by himself on a daily basis and priority repairs are communicated to

maintenance and/or housekeeping staff for completion; the system functions the best when all staff utilize the program and reports areas of concern. [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 the home, furnishings and equipment are kept clean, sanitary, maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 16, by not ensuring that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The following observations were made:
- Birch Unit – the window at the end of the hall was observed to be opened approximately fifteen inches (~37cm); the screen on this same window was bent and loose. This window is located on the second floor of the home where residents reside. (October 27, 2014)

- Birch Unit – Room #B18A – the window was observed to be open approximately fifteen inches (~37cm). This window is located on the second floor of the home where residents reside. (October 28, 2014)

The two identified window issues (opening > 15cm) were brought to the attention of the Administrator on the dates indicated above; windows were attended to by the Environmental Services Manager and the issue(s) were resolved on October 27 and 28, 2014.

Observations by Inspector #541:
- Windows opening greater than fifteen centimeters were identified in resident washrooms in Room(s), Maple #4 and Pine #11

The ESM indicated that an AirCon system had been removed from the two windows on the Birch Unit and it was an oversight of the department in not replacing the locking system that controls the opening of the windows following removal of the units.

The Administrator, as well as the ESM had no knowledge of the windows opening greater than fifteen centimetres prior to such being brought to their attention. On November 7, 2014 the windows openings were adjusted to not open greater than 15 cm. [s. 16.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. Related to Log #O-000903-14 for Resident #48:

The licensee failed to comply with LTCHA, 2007, s. 22 (1), by not ensuring that any written complaint received concerning the care of a resident or the operations of the home is immediately forwarded to the Director.

The Action Line was contacted on a specified date by Complainant #75 voicing concerns relating to Hot Weather Temperature. The complainant indicated having had contacted the Administrator 6 days prior as to excessive temperatures within the home, but had not received a response from the home's Administrator; complainant remained concerned not only for loved one but other residents residing in the home.

The Administrator, during an interview on November 03, 2014, indicated receiving a written (email) from the complainant on a specified date specific to home temperatures; Administrator stated that the written complaint had not been forwarded to the Ministry of Health and Long Term Care.

Administrator indicated being aware that all written complaints were to be forwarded to MOHLTC and could not comment as to why the complaint by Complainant #75 had not been forwarded. [s. 22. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any written complaint received concerning the care of a resident or the operations of the home is immediately forwarded to the Director, to be implemented voluntarily.

WN #12: 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 failed to comply with O. Reg. 79/10, s. 37 (1)(a), by not ensuring that each resident of the home has 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.

The following observations were made:
- Birch Room #6 – a toothbrush was seen lying on the counter in a shared (semi)washroom; the item was unlabelled. There is signage on the door indicating contact isolation/precautions.
- Birch Room #9 – a toothbrush and a denture cup were seen lying on the washroom vanity in a shared (semi) washroom; these items were unlabelled.
- Birch Room #24 – used disposable razors (3), denture cup and a tooth brush were seen lying on the washroom vanity in a shared (semi) washroom; these items were unlabelled. This room has signage on door indicating contact isolation/precautions.
- Maple Room #1 – a toothbrush inside of a toothbrush holder was seen lying on the washroom vanity in a shared (ward) washroom; the items were unlabelled.
- Maple Room #3 – a toothbrush was seen lying on the washroom vanity in a shared (ward) washroom; the item was unlabelled.
- Maple/Birch Tub Room – a hairbrush (used, contains hair) was observed sitting on the counter top in the shower area of this room. This is a communal care area.

Staff #133, 134 and 135, all indicated that personal care items are to be labelled as to which resident supplies belong too.

The DOC indicated that all resident care and/or grooming supplies (personal care) are to be labelled for individual resident use. The DOC indicated that all staff should label items when it is observed that items have no names (in addition to new admission items and new supplies). [s. 37. (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 each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labeled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 86 (2)(b), by not ensuring there are measures in place to prevent the transmission of infections.

The following observations were made on specified dates:
- A soiled incontinence product was observed lying on the counter top in the Linden Tub Room; during this same observation, soiled washcloths, towels, incontinence bed pad and pyjamas were observed in a sink in this same room.
- A soiled incontinence product, washcloth and towels were observed lying on the floor in a specified room.
- A soiled incontinence product and clothing were observed on the floor in a specified room.

The DOC indicated that at no time is any soiled product(s) or clothing to be placed on the floors in any area.

Other observations:
- A urinal was observed sitting on the back of a toilet in the Maple/Birch tub room; during this same observation a bed pan was seen lying on the floor in this same area. Both items were unlabelled; this is a communal resident care area.
- A urinal was observed was observed sitting on the back of the toilet in the Maple

/Birch tub room, during this same observation a grey bed pan was seen lying across an open seat on the toilet. Both items were unlabelled; this is a communal resident care area.
- A urinary catheter draining bag and tubing were observed lying in a basin under a sink in the washroom, of a specified room; the urinary drainage bag was unlabeled and soiled. During this same observation, an unlabelled urinal was seen sitting on the back of the toilet; this is a shared basic resident room.
- A urinary catheter drainage bag and tubing was observed hanging on a towel bar next to towels in the washroom of a specified room; the urinary drainage bag was unlabeled and soiled. During this same observation, an unlabeled urinal was seen lying on the back of the toilet; this is a shared (semi) resident room.

The home's policy, Equipment Cleaning (RSL-SAF-080) directs that bedpans and urinals are to be labelled for individual resident use and to be stored in a designated area.

Staff #133, 134 and #135 all indicated being aware of the home's policy and confirmed the practice of the home is to ensure all that resident care items (e.g. bedpans and urinals) are labeled with resident's name; items are to be stored clean and in each resident's night stand. Staff #134 indicated that one resident in one specified room is independent in caring for own catheter and changing over the larger urinary drainage bag to a smaller one each morning. Staff #134 indicated it is the staff's responsibility to ensure the catheter equipment is stored appropriately.

The DOC indicated that all bedpans and urinals are to be labeled for individual resident use and are not to be stored in communal resident washrooms. The DOC indicated that residents in rooms two specified rooms are independent in catheter care and have been reminded numerous times to properly store equipment.

Note: There are numerous rooms within the home (all resident home areas) which have identified residents colonized with Antimicrobial Resistant Organisms; the DOC has provided confirmation that incidence of Health Care Worker transmission has been identified within the home. [s. 86. (2) (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 there are measures in place to prevent the transmission of infections, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. As part of the organized program of maintenance services under LTCHA, 207 s. 15 (1)(c), the licensee has failed to comply with O.Reg 79/10 s. 90(2)(a) in that they did not ensure mechanical lifts are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum.

Log #O-001202-14

On a specified date in 2014, staff #141 documented that 2 staff were transferring Resident #49 from bed to wheelchair by a full mechanical lift (ergo). During the transfer, the resident was on the sling up in the air over the wheelchair, all of a sudden the mechanical lift tilted entirely with the sling backward and the resident landed in the wheelchair. Resident Care Manager (RCAM) and maintenance were notified and lift was taken to be repaired.

On November 6, 2014 interview with RPN #141 indicated that on the date of the incident two PSWs were transferring Resident #49 from bed to wheelchair when the whole lift tilted entirely backwards with the resident. The lift had a defect or a problem and could not tell what was wrong with the lift.

On November 6, 2014 interview with Environmental Services Manager (ESM) indicated that lifts are inspected on monthly basis for preventative maintenance. The lifts are checked for the up and down and legs for out and close. If the lift is defective it will be removed for repair.

Review of a note by maintenance staff # indicated that an Ergo lift was tagged out of service and removed for inspection by maintenance on the date of the incident, after the incident. A note by ESM indicated that the lift was tagged out in the maintenance shop from the date of the incident and a request for inspection was sent to Arjohuntleigh on October 8, 2014.

Review of Arjohuntleigh service call report dated October 14, 2014 indicated the Ergo lift Maple #3 serial number ERLI-1887 was inspected and found that the legs were loose and not aligned properly. The lift was repaired and technician suggested the some parts of the lift to be replaced including: 1 braked caster, emergency stop switch, hanger bar cover and pin assembly. The recommended parts were replaced on October 23, 2014. Until the final repair was completed, the lift was kept in the maintenance shop.

Review of Monthly Lifting Devices Inspection records for specified dates indicated that all lifts were inspected and no problems noted. The lifting device labelled Ergo lift Maple #3 serial number ERLI-1887 was not included on the list of devices inspected.

The ESM indicated that the lifting device Ergo lift Maple #3 serial number ERLI-1887 was not listed in the home's assets list. The ESM could not confirm if the lift was inspected at all by maintenance staff as it was not included in the Monthly Lifting Devices Inspection list.

There is no documented evidence that the Ergo lift Maple #3 serial number ERLI-1887 was inspected to be in good repair and safe for use prior to the incident on a specified date. [s. 90. (2) (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 mechanical lifts are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum., to be implemented voluntarily.

WN #15: 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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

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

Review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- If an employee(s) is involved, immediately notify of the pending investigation requiring alleviation from duty pending completion of the investigation, including reporting requirements to the Director (MOHLTC) and local police authorities.
-The Registered Staff and the person discovering the abuse shall prepare a written incident report. All documentation of an alleged, actual, or suspected abuse incident will use descriptive and precise language free from opinion and conjecture. The report shall contain the following information and shall be submitted to the Administrator, General Manager, Director of Care, Wellness Coordinator and/or designate: what occurred, when it occurred, who was involved (including the names of witnesses or those who were in the vicinity when it occurred), what was observed/heard, written statements from witnesses including information pertaining to the incident.
-the Registered staff will report the alleged, actual, or suspected abuse to the Administrator, General Manager, Director of Care, Wellness Coordinator, and or designate, local police authorities, and the Director (MOHLTC).
-the Registered staff will immediately notify the Resident's substitute decision maker, if any and any other person specified by the Resident, and they are to be notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a Resident.
-the Registered staff will update the plan of care and progress notes following the incident as appropriate, inclusive of measures to assess the Residents physical and /or psychosocial well-being post incident as well as interventions to prevent recurrences.

On a specified date the Administrator was notified by Inspector of a staff to resident emotional abuse towards Resident #29. The following day, the Administrator was notified by Inspector of three more reports of staff to resident verbal abuse or neglect towards Resident #8, #15 & #30 that were received during stage 1 of the Resident Quality Inspection. The Administrator indicated that the incidents would be investigated immediately.

Interview of the DOC by Inspector #554 indicated that all allegations of resident abuse involving nursing staff are forwarded to the Director of Quality Nursing (DQN) to complete the investigation.

The DQN indicated he was notified of the allegations of staff to resident abuse/neglect approximately two days prior and initiated the investigations for Resident #8, #15 &

#30 on a specified date using the client feedback forms. The DQN indicated that the Administrator had completed the "client feedback" form for Resident #29 and was on the Administrator's desk. The DQN was not aware a "Resident Incident Report" was to be completed for allegations of abuse instead of a "Client Feedback" form. Later in the day, the DQN provided the inspector with copies of "Client Feedback" forms" for 3 out of the 4(for Resident #8, 15, & #30) who reported allegations of staff to resident abuse/neglect. There was no indication that any of the staff had been interviewed or notified of the allegations (despite working during that time period) or any other actions taken 4 days after the allegations were reported to the home.

There was no documented evidence that when the allegations of staff to resident abuse/neglect for Resident #8, #15, #29 & #30 were reported to the Administrator on specified dates, that the Administrator completed the resident incident report as indicated in the home's policy as "the person discovering the abuse" . The progress notes and plan of care were not updated regarding the allegations, as well as interventions to prevent recurrence and no indication that the substitute decision makers of the residents were notified of the allegations. [s. 20. (1)]

2. Related to Log #O-001171-14 for Resident #42:

Complainant #76 contacted Registered Practical Nurse #148 on a specified date and reported an allegation of verbal abuse directed toward Resident #42 by a staff member.

Staff #148, who was the charge nurse on the unit, Registered Nurse Supervisor, who was in charge of the home on the date of the allegation and RCAM #145 who became aware of the allegation of verbal abuse on a specified date all failed to:
- provide support and reassurance to the resident affected. As per interview on November 7, 2014, RCAM indicated not speaking with the resident following becoming aware of the incident
- immediately report the allegation of verbal abuse to the MOHLTC
- complete an incident report including, what occurred, when it occurred, who was involved, names of witnesses, where it occurred, what was observed and heard, nor was the allegation or report of such submitted to the Administrator, Director of Care and or designate; staff indicated Registered Nursing Supervisor directed staff to place the family complaint in the progress notes
- contact Administrator, Director of Care or designate as to the allegation of verbal abuse. During interview with the RCAM on November 7, 2014, she indicated forgetting to advise the DOC of the allegation.

- did not meet with any staff working the day of the allegation, as indicated Staff #148 spoke with two of the staff working that day and staff felt allegation unfounded. RCAM indicated that there were at least three other staff working the day shift indicated.
- contact the Resident and/or substitute decision maker following becoming aware of the incident and/or awareness of the outcome.

As of November 06, 2014, the Director of Care was investigating the concern of Complainant #76.

2) Related to Log #O-000658-14 for Resident #16:

An incident of Staff to Resident Verbal Abuse occurred on a specified date; the personal support worker involved with the incident was placed on a leave pending the outcome of the investigation.

The Registered Practical Nurse (#124), who was the charge nurse on the unit at the time of the incident reported the verbal abuse to Registered Nurse (RCAM #125), who was in charge of the home during the day shift on the date of the incident.

According to CIATT, MOHLTC was not notified of the incident until the following day.

Staff #124 and Resident Care Area Manager #125 both failed to:
- immediately contact MOHLTC as to the incident of Staff to Resident verbal abuse as per the Home`s policy.

3) Related to Log #O-000584014 for Resident #50:

According to a Critical Incident Report submitted, by the home's former Director of Care, on a specified date in an incident of alleged Staff to Resident (verbal/physical) Abuse was reported to have occurred on one day earlier.

Details of the CI are as follows:
Resident #52 reported hearing a staff member yelling at Resident #50 in the hallway sometime during the night; Resident #52 reports hearing staff yell at Resident #50 to go back to bed and then reports hearing a slapping sound followed by a yelping sound from Resident #50. According to the CI report, Resident #52 reported the incident to family; in turn, Resident #52's family reported the incident of verbal/physical abuse to Resident Care Area Manager (RCAM #123).

The home's Director of Quality-Nursing and the former Director of Care who was involved with the investigation failed to:
- contact the local police authorities of the allegation of physical abuse as per the Home`s policy. [s. 20. (1)]

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse or neglect of a resident by anyone that the licensee knows of, or that was reported was immediately investigated.

1.During stage one of the Resident Quality Inspection Oct 27-30, 2014:
-Interview of Resident #8 (by Inspector # 554) stated they "had a confrontation with a staff member, and at the time, I hurt my arm, had to use manual chair, and they left me in the dining room. I asked staff member "Can you take me back? I had to ask several times". Staff responded "I'm looking after a specified unit not your unit, get someone else."

Review of the progress notes for Resident #8 indicated during the care conference on a specified date, the home was notified of the resident's concern of neglect of care and indicated a "client feedback form was completed" at that time. The client feedback form or an investigation into the allegation could not be found. A "Client Feedback" form was provided to the inspector by the DQN on November 4, 2014 indicating Resident #8 had been re-interviewed and identified the staff member involved in the allegation of staff to resident neglect as PSW#136 but the staff member had not yet been interviewed. Review of the staff schedule for PSW #136 indicated the PSW worked evening shift on 6 occasions following the home becoming aware of the incident.

-Interview of Resident #30 stated "a couple of weeks ago, a staff member was yelling at me in the morning when they were washing my face but I don't know their name". On October 30, 2014 the Administrator was notified of the allegation of staff to resident verbal abuse towards Resident #30. Review of the "Client Feedback" form provided by the DQN indicated on November 4, 2014 the resident was interviewed by the DQN and indicated PSW #137 was the staff member allegedly involved in staff to resident verbal abuse. The form indicated staff member had not yet been interviewed regarding the allegation. Review of the PSW schedule indicated that PSW#137 worked 5 day shifts after the home became aware of the incident.

2. Related to Log #00051:

A critical Incident Report was received on a specified date for a resident to resident sexual abuse incident that occurred the day before. The CIR indicated at a specified time Resident #55 was seen walking with a PSW towards his/her room crying uncontrollably. The Charge Nurse asked the resident why he/she was crying and stated that Resident #54 was sitting on a chair across from him/her at the nursing station Resident #54 inappropriately touched Resident #55 and made a sexual gesture. Resident #55 was reassured and provided emotional support, head to toe completed with no noted injuries.

Review of the progress notes for Resident #54 (from a specified date range) indicated:
-on a specified date the resident was observed "displaying inappropriate sexual behaviour towards another resident". The PSW observed the resident inappropriately touch another resident. There was no indication which resident and no documented evidence of an investigation.
-on a specified date and time staff overheard voices in the residents room and when

entered the room, found another resident laying in the resident's bed. The resident was distracted while staff removed the other resident from the room. There was no incident report completed and no indication who the other resident was.
-on a specified date and time the resident was found in his/her room with door closed and Resident #57 in the room. Staff removed Resident #57 from the room. The resident followed them out of the room and then sat with Resident #57 near nursing station. The Resident was then observed inappropriately touching Resident #57 and when the PSW attempted to separate them the resident hit the PSW on the hand. Resident #57 was taken to his/her room. The POA of resident was not notified of incident.

Review of the homes investigations and interview of staff indicated there was no investigations completed related to witnessed or suspected incidents of sexual abuse that occurred on 3 specified dates in 2014. [s. 23. (1) (a)]

2. Related to Log #O-000584-14 for Resident #50:

The licensee failed to comply with LTCHA, 2007, s. 23 (1) (b), by ensuring that the appropriate action is taken in response to every such alleged, suspected or witnessed incident of abuse of a resident by anyone.

According to a Critical Incident Report submitted, by the home's former Director of Care, on a specified date an incident of alleged Staff to Resident (verbal/physical) Abuse was reported to have occurred one day earlier. The CI was later amended indicating the incident of alleged abuse was to have occurred on or about 3 days prior to the previous date submitted.

Details of the CI are as follows:

- Resident #52 reported hearing a staff member yelling at Resident #50 in the hallway sometime during the night; Resident #52 reports hearing staff yell at Resident #50 to go back to bed and then reports hearing a slapping sound followed by a yelping sound from Resident #50. According to the CI report, Resident #52 reported the incident to family; in turn, Resident #52's family reported the incident of verbal/physical abuse to Resident Care Area Manager (RCAM #123).
- Resident #50 was assessed by RCAM on a specified date; no injury was visible. Resident did not recall the incident due to poor short term memory.

During an interview, on November 04, 2014, the Director of Care and Director of

Quality-Nursing, indicated that RCAM #123 notified the former Director of Care of the allegation of Abuse on the date he/she became aware of it.

Director of Quality indicated that Resident #52 was interviewed on or about a specified date; resident indicated in the interview that the incident did not occur on a specified date but occurred two days prior on the Saturday at a specified time; according to the Director of Quality, Resident #52 indicated over hearing the incident, but did not look into the hallway to see which staff was involved nor was the incident reported to anyone on the night of the incident.

Director of Care indicated that Resident #52 has since deceased but was cognitively well when the incident was reported.

Director of Care (current) indicated that there were three staff (a Registered Practical Nurse and two Personal Support Workers) assigned to work the night shift, on Resident #50 and #52's home area, on the Saturday in question. DOC indicated not being involved with the staff interviews, and deferred further comments to the Director of Quality.

Director of Quality-Nursing stated that he and the former Director of Nursing interviewed the three staff as to the allegation of Abuse; Director of Quality indicated Staff #120, #121 and #122 were not interviewed as to the allegations until 7 and 8 days after the home becoming aware of the incident.

A review of the home's Staffing Assignment Schedule, for a specified date range, indicated that Staff #120, #121 and #122 worked shifts following the allegation and prior to being interviewed by the licensee or its designate on dates indicated above.

Director of Quality could not comment as to why there was a delay in investigating the incident of alleged Staff to Resident Abuse.

Director of Quality commented the investigation as to the allegation of abuse was completed on a specified date and findings were inconclusive.

Director of Quality indicated that the practice of the home is to immediately investigate all allegations of suspected or witness abuse and that during the investigation, staff alleged to be involved are normally placed on a leave of absence pending the outcome of the investigation. [s. 23. (1) (b)]

3. Related to Log #O-001171-14, for Resident #42:

Complainant #76 contacted the home on a specified date, to report that Resident #42 had asked a staff member to turn off the television, as remote control was not within resident's reach; complainant indicated that a staff member stated, to the resident, "I'm not your bloody slave". Complainant indicated being concerned as to the way his/her loved one is being treated in the home when family is not around.

Complainant #76 stated the concern surrounding verbal abuse was brought to the attention of Registered Practical Nurse #148, who was the Charge Nurse working on Birch Resident Home Area that day.

Staff #148, during an interview on a specified date, indicated that only two of the day staff were spoken with as to the allegation and both had denied such. Staff #148 indicated only staff wearing glasses were spoken with as the complainant commented that Resident #42 thought the individual having made the comment was wearing glasses.

Staff #148 indicated not speaking with Resident #42 as to the allegation as family were the one's making the complaint not the resident; staff indicated Resident #42 was cognitively well.

Staff #148 indicated communicating the concern to the Registered Nurse Supervisor, in charge of the home, on the date of the allegation, who directed to place the complaint into the progress notes.

Resident Care Area Manager (RCAM #145) indicated being made aware of the allegation of verbal abuse on 2 days after the allegation while reading weekend progress notes but stated nothing further was needed to be done as two of the day staff were spoken to on a specified date by Staff #148 and the situation was deemed unfounded. RCAM indicated not speaking to Resident #42 nor the family as to the complaint.

RCAM #145 stated that the allegation of verbal abuse was not brought to the attention of the Director of Care as she had forgotten to.

Administrator indicated that the Registered Practical Nurse, Registered Nurse and Resident Care Area Manager should have spoken to the resident, family and all staff specific to the allegation of verbal abuse. [s. 23. (1) (b)]

4. The licensee has failed to ensure that appropriate action was taken in response to every such incident of abuse and/neglect.

-Interview of Resident #15 on a specified date stated "a staff member yells at him/her and is rude". The Administrator was notified of the allegation the following day. Review of the "client feedback form" provided by the DQN on a specified date indicated that PSW #134 was the alleged staff member involved in the incident and was to be interviewed by the DOC. Review of the staff schedule indicated that PSW #134 had worked 3 day shifts between from the date of the allegation until the home provided Inspectors with the client feedback form.

- Resident #29 stated during an interview on a specified date that "I had an earache and reported it to the RPN who told me the doctor would be in tomorrow to assess. The following day I saw the physician but he did not come to see me. A week later, the physician came in to see me and I stated I still have the earache and the physician said very loudly and abruptly to me "do you realize people die here". I just wanted my ear ache dealt with but I didn't like that." On a specified date the Administrator was notified of the allegation of physician to resident emotional abuse towards Resident #29. Review of the homes investigation indicated on a "client feedback log" on the date the home became aware of the incident, the resident was interviewed and confirmed what was reported to the inspector. The form indicated under further action: "speak to Dr." to be completed by Administrator and DOC. There was no indication the physician was interviewed as of 7 days later and the physician had been in the home on 4 times since the home becoming aware of the incident. [s. 23. (1) (b)]

WN #17: 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. Related Log #O-000658-14 for Resident #16:

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

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

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by another other than a resident.

A home's former Director of Care, submitted a Critical Incident Report on a specified date. The CI details an incident of Staff to Resident (verbal) abuse, which was said to have occurred 2 days prior; details of the incident are as follows:

- Staff #119 was asked by Resident #16 to make resident's bed; Resident #16 called

staff 'a lazy bitch'. Staff #119 responded 'I'm not a bitch, you are the bitch'.

The allegation of Staff to Resident (verbal) abuse was reported by the Registered Practical Nurse (#124) to the Resident Care Area Manager (RCAM #123), who was the supervisor in the home during the incident which occurred on a specified date.

According to the CI report, the RCAM contacted the Director of Care of the incident.

The incident of Staff to Resident Verbal Abuse was not reported to the Director within the timeframe required by legislation.

The DOC and the Director of Quality-Nursing both indicated awareness of the requirements under Section 24. [s. 24. (1)]

2. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm was immediately reported to the Director.

Related to log 000551:

Review of the progress notes for Resident #54 indicated:
-on a specified date and time the resident was found in his/her room with door closed and Resident #57 in the room. Staff removed Resident #57 from the room and the resident followed them out of the room as well. The resident then sat with Resident #57 at the nursing station and was observed "inappropriately touching Resident #57 and when the PSW attempted to separate them the resident hit the PSW on the hand" Resident #57 was taken to his/her room.

Interview of the DOC indicated the incident was not reported to the Director. [s. 24. (1)]

3. Related to Log #O-001171-14 for Resident #42:

The licensee failed to comply with LTCHA, 2007, s. 24 (1), by not ensuring that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director;
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by another other than a resident.

Complainant #76 contacted the home on a specified date and time to report that Resident #42 had asked a staff member to turn off the television, as remote control was not within resident's reach; complainant indicated that a staff member stated, to the resident, "I'm not your bloody slave". Complainant indicated being concerned as to the way his/her loved one is being treated in the home when family is not around.

Resident #42, during an interview on a specified date, indicated feeling belittled by the comment of staff; resident further commented 'I can't wait to get out of this place'.

Complainant #76 stated the concern surrounding verbal abuse was brought to the attention of Registered Practical Nurse #148, who was the Charge Nurse, working on Birch Resident Home Area that day.

Staff #148 commented during an interview on a specified date, that the allegation of verbal abuse was brought to the attention of the Registered Nurse Supervisor, who was in charge of the home, on November 01, 2014.

Staff #148 indicated that MOHLTC was not contacted as to the allegation of verbal abuse, as that is not staff's role, but a supervisor's job.

Resident Care Area Manager (#145) indicated awareness of the allegation but commented such was not reported to Director.

The DOC indicated no awareness of Complainant #76's allegation of verbal abuse.

The Administrator indicated that all staff are to report allegations of Abuse. [s. 24. (1)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. Related to log #000551:

The licensee has failed to ensure that direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours require heightened monitoring because those behaviours pose a potential risk to the resident or others.

A critical Incident Report was received on a specified date for a resident to resident sexual abuse incident that occurred on a specified date and time. The CIR indicated at a specified time Resident #55 was seen walking with a PSW towards his/her room crying uncontrollably. The CN asked the resident why he/she was crying and Resident #55 stated that Resident #54 was sitting on a chair across from him/her at the nursing station and reached over and placed his/her hand between his/her legs, touching his/her private area and then touched him/herself.

Review of the current care plan for Resident #54 indicated the resident is diagnosed with cognitive impairment, is independently mobile, and demonstrates specified responsive behaviours and specified strategies to deal with the responsive behaviors.

Interview of PSW #101 by Inspector #541 who works part time on the unit where Resident #54 resides, had no knowledge of the Resident's demonstrated behaviours of physical aggression and sexually inappropriate behaviours. [s. 55. (b)]

WN #19: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. Related to Log #O-000658-14, for Resident #16:

The licensee failed to comply with LTCHA, 2007, s. 76(4), by not ensuring that all staff have received retraining annually relating to the following:
• The Residents' Bill of Rights
• The home's policy to promote zero tolerance of abuse and neglect of residents
• The duty to make mandatory reports under section 24
• The whistle-blowing protections

An incident of Staff to Resident abuse was reported to CIATT (Centralized Intake, Assessment and Triage Team) on a specified date involving Staff #119. The investigation by the home, concluded on or about 2 days later, concluding Resident #16 was verbally abused by Staff #119.

A review of annual education records (SURGE Learning) specific to Staff #119 failed to provide evidence to support that this staff member received retraining specific to Zero Tolerance of Abuse, Section 24, and Resident Bill of Rights in 2013, nor prior to incident (allegation of abuse) which occurred on a specified date.

According to staff annual education records, Staff #119 has since received education, as described above, on September 24 and September 28, 2014.

The DOC indicated it is the practice of the home that all staff receive annual re-training specific to Zero Tolerance of Abuse and Resident's Bill of Rights. The DOC did confirm that Staff #119 did not complete re-training in 2013 nor prior to to the incident on June 07, 2014. [s. 76. (4)]

WN #20: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Residents' Council is sought in developing and carrying out the satisfaction survey, and in acting on its results.

On November 3, 2014 during an interview with Inspector #541, Resident Council President was unable to recall the satisfaction survey being discussed with the Resident's Council.

On November 4, 2014 during an interview with the Program Manager, she confirmed that because the resident satisfaction survey is administered by a third party, the advice of the resident's council was not sought in the development of the survey. This was confirmed by the Administrator on November 6, 2014. [s. 85. (3)]

2. The licensee has failed to ensure that the advice of the Family Council is sought in developing and carrying out the satisfaction survey.

On November 5, 2014 during a phone interview with Inspector #541, the president of the family council stated that no input from the council was sought in the development of the satisfaction survey. On November 6, 2014 during an interview with Inspector #541 the Administrator confirmed that the advice of the Family Council was not sought in the development of the satisfaction survey. [s. 85. (3)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's written policy to promote zero tolerance of abuse and neglect of residents identified the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation.

Review of the homes policy "Required Abuse and Neglect Reporting" Revised July 1, 2012 (HRM-POL-003) under procedures (items 5-8)indicated:
5. If an employee(s) is involved, immediately notify of the pending investigation requiring alleviation from duty pending completion of the investigation, including reporting requirements to the Director (MOHLTC) and local police authorities.
6.Any person who witnesses, suspects, becomes aware of or is involved in abuse or neglect of a Resident are required to immediately report the abuse or neglect incident to the Administrator or General Manager and or Director of Care or Wellness Coordinator, and/or designate.

7. The Administrator, General Manager, Director of Care, Wellness Coordinator and/or designate will immediately report the incident to the Director (MOHLTC) and local police authorities. Subsequent immediate mandatory critical incident system reporting will be completed for the Long Term Care homes only.
8. The Registered Staff and the person discovering the abuse shall prepare a written incident report.
Interview of the Director of Care (DOC) by Inspector #554 indicated that all allegations of abuse and/or neglect related to nursing staff are forwarded to the Director of Quality Nursing (DQN) to complete the investigation.
Interview of the Director of Quality Nursing (DQN) by Inspector #111 on November 4, 2014 indicated that when the Administrator is notified of allegations of staff to resident abuse/neglect, are by nursing staff, it is forwarded to DOC, who then forwards it to the DQN to complete the investigation. The DQN indicated "any of the managers could complete the client feedback form". The DQN indicated that the DOC and/or Administrator also completed interviews during investigations. The DQN indicated he was notified of the allegations of staff to resident abuse/neglect approximately two days ago (November 2, 2014). The DQN indicated that the Administrator had completed the client feedback form for Resident #29's allegations but he had not completed the "client feedback form" for any of the remaining 3 allegations (for Resident #8, 15& #30) and would initiate the investigations today. The DQN was not aware a "Resident Incident Report" was to be completed for allegations of abuse/neglect instead of a "Client Feedback Form" and was provided a copy of the "Resident Incident Report" form during the interview. On November 5, 2014, the DQN provided the inspector copies of "Client Feedback Forms" for 3 out of the 4 reported allegations (for Resident #8, 15, & #30) of staff to resident abuse/neglect. The DQN indicated only the resident's had been interviewed regarding the allegations and staff members identified. The DQN indicated that the "Client Feedback Form" for Resident #29 was completed by the Administrator and was on the Administrator's desk. There was no indication that any of the staff had been interviewed or notified of the allegations (despite working or in the home during that time period).

Under this policy, item #5 does not indicate who is responsible to immediately notify the staff of the pending investigation. Item #6 indicates that any person, who witnesses, suspects or becomes aware of or is involved in abuse or neglect of a Resident is required to immediately report to Administrator or General Manager but does not indicate when it is the Administrator (who receives the report of abuse or neglect) what their responsibility is. Item #7 indicates only the Administrator, General Manager, DOC, Wellness Coordinator or designate will report incidents to Director (MOHLTC) and local police authorities but there is no "General Manager"' or

"Wellness Coordinator" position in the home. The policy does not reflect the current practice in the home where the Administrator (who received 4 allegations of abuse and/or neglect) notified the Director of care, who then notified the Director of Quality Nursing" who was then responsible for completing the investigations. The DQN also indicated that the investigations where to be completed in conjunction with the DOC and/or Administrator. [s. 96. (d)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

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

detrimental to the resident's health or well-being.

During stage one of the Resident Quality Inspection which took place October 27-30, 2014:
-interview of Resident #30 stated: "a couple of weeks ago, a staff member was yelling at me in the morning when they were washing my face but I don't know their name". The resident did not report the incident to anyone.
-interview of Resident #8 (by Inspector # 554) stated they "had a confrontation with a staff member, and at the time, I hurt my arm, had to use manual chair, and they left me in the dining room. I asked staff member "Margaret can you take me back? I had to ask several times". Staff responded "I'm looking after Maple not Birch, get someone else."

The Administrator was notified of the above allegations of staff to resident emotional abuse and neglect by Inspector #111 on October 29, 2014. Review of the homes investigation for Resident #30 indicated on November 4, 2014 the resident was re-interviewed by the DQN but there was no indication the SDM was notified. Review of the homes investigation for Resident #8 completed by the DQN indicated on November 4, 2014 the resident was interviewed but no indication the SDM was notified.

Review of the health care records for Resident #30 had no documented evidence that the SDM, or any other person specified by the resident were notified of an alleged incident of verbal abuse. Review of the health care record for Resident #8 indicated a care conference note indicated the home was notified of the resident's concern of neglect of care regarding that incident and a "client feedback form was completed". Inspector #554 reviewed the complaint binder and there was no indication of a "client feedback form" completed or an investigation to indicate the SDM was notified of the alleged staff to resident neglect. A "client feedback form" (home's investigation) was provided to the inspector by the DQN on November 4, 2014 indicating Resident #8 had been re-interviewed but the SDM had still not been notified. [s. 97. (1) (a)]

2. Related to Log #O-001171-14 for Resident #42:

The licensee failed to comply with O. Reg. 79/10, s. 97 (2), by not ensuring that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Complainant #76 reported an allegation of verbal abuse on a specified date to

Registered Practical Nurse #148, who is the unit Charge Nurse. Complainant indicated that to date no one from the home has contacted the family as to the allegation or the outcome of any investigation.

Complainant indicated that this is not the first complaint and that family is concerned as to how their loved one is being treated when family are not present.

Staff #148, during an interview on a specified date, indicated not contacting the complainant following family voicing their concern on a specified date; staff indicated communicating concern to the Registered Nurse Supervisor, who was in charge of the home and working the day of the allegation.

Resident Care Area Manager #145, who oversees the care area where Resident #42 resides, indicated being aware of the allegation but indicated neither the resident nor family had been contacted by her. RCAM indicated that she felt the situation was resolved as staff had denied the allegation; RCAM did not feel the need to contact family.

The DOC indicated no awareness of the allegation which occurred on a specified date and agreed that someone should have contacted the family as a follow up. [s. 97. (2)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. Related to Log #O-000584-14 for Resident #50:

The licensee failed to comply with O. Reg. 79/10, s 98, by not ensuring that the appropriate police force is immediately notified of any alleged, suspected, or

witnessed incident of abuse of a resident.

According to a Critical Incident Report submitted, by the home's former Director of Care, on a specified date an incident of alleged Staff to Resident (verbal/physical) abuse was reported to have occurred on one day earlier. The CI was later amended indicating the incident of alleged abuse was to have occurred on or about two days prior to the original date submitted.

Details of the CI are as follows:

- Resident #52 reported hearing a staff member yelling at Resident #50 in the hallway sometime during the night; Resident #52 reports hearing staff yell at Resident #50 to go back to bed and then reports hearing a slapping sound followed by a yelping sound from Resident #50.
- According to the CI report, Resident #52 reported the incident to family; in turn, Resident #52's family reported the incident of verbal/physical abuse to Resident Care Area Manager (RCAM #123).

The DOC and Director of Quality both indicated the allegation of abuse (verbal/physical) was not reported to the police.
The Director of Quality, who was present during the investigation of the abuse, indicated the incident was not reported to the police as Resident #50 was assessed by registered nursing staff and found to have had no visible injuries nor could resident recall the incident. [s. 98.]

2. Related to Log #000551:

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

A Critical Incident Report (CIR) was submitted by the home on a specified date for a resident to resident sexual abuse incident that occurred on a specified date and time. The CIR indicated Resident #55 was seen walking with a PSW towards own room and "was crying uncontrollably". When CN ask resident why the he/she was crying, the resident stated that Resident #54 was sitting on a chair across from him/her at the nursing station when [Resident #54] reached over and placed his/her hand between his/her legs, touching his/her private area and then touched him/herself. The CIR had no indication that police were called.

Review of the progress notes for Resident #55 and Resident #54 on the date of the incident had no indication the police were notified.

Interview of the DOC indicated that if it was not indicated on the CIR then they were not notified. [s. 98.]

Issued on this 30 day of January 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : AMBER MOASE (541) - (A1)

Inspection No. / No de l'inspection : 2014_280541_0035 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-001065-14 (A1)

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

Report Date(s) / Date(s) du Rapport : Jan 30, 2015;(A1)

Licensee / Titulaire de permis : COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

LTC Home / Foyer de SLD : COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Mona Babb

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

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

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

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

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

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to achieve compliance with O. Reg. 79/10, s. 101.

The licensee shall ensure the plan includes:
- a review the home's policy relating to complaints and or concerns for all staff; awareness of roles and responsibility as it relates to the same
- a process in place to ensure complaints and concerns received are documented/recorded, investigated, resolution made were possible and outcome communicated with resident or family
- a process in place to ensure complaints documented are reviewed and analyzed for trends at least quarterly; and that the review is used to make improvements within the home
- a process in place to monitor that all written complaints received are forwarded to the MOHLTC, along with the outcome of the investigation and accompanying resolution
- measures in place when non-adherence to the home's policy and or legislation is identified

The plan shall be submitted in writing and emailed to Inspector, Amber Moase at amber.moase@ontario.ca on or before February 2, 2015. The plan shall identify who will be responsible for each of the corrective action listed.

Grounds / Motifs :

1. Related to log #O-000903-14 for Resident #48:

The licensee failed to comply with O.Reg.79/10, s.101 (1)1 by not ensuring that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home:
• has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and
• where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately investigated

The Action Line was contacted on a specified date by Complainant #75 voicing concerns relating to Hot Weather Temperature. The complainant indicated having had contacted the Administrator 6 days prior as to excessive temperatures within the home. The Administrator, during an interview on November 03, 2014, indicated

receiving a written (email) complaint from Complainant #75 on a specified date; details of the complaint were as follows:

- Complainant indicated visiting a family member (a resident of the home) on several occasions; while sitting in the dining room assisting resident observed sweat pouring of the faces of kitchen and nursing staff, as well as off the faces of many of the residents. Complainant indicated during the same observation, resident's faces being flushed. The written complaint indicated the temperatures in the dining room were oppressively hot and quite unbearable.

The Administrator provided further email correspondence written by Complainant #75 on three other dates requesting a meeting with the Administrator and Resident Care Area Manager to discuss excessive hot temperatures and other concerns. The Administrator did comment that a meeting with the complainant occurred on a specified date, but agreed the meeting and or communication was twenty days following the initial complaint.

According to the Meeting Minutes, on a specified date, the response provided by the Administrator to the Complainant, surrounding excessive temperature within the home, was 'everything that could be done was being done'.

The Administrator indicated that an investigation relating to complainants concerns was not completed as the home was doing everything possible to control the home's heating and cooling.

The Environmental Services Manager (ESM), on a specified date, indicated no awareness of this complaint with regards to excessive temperatures within the home. [s. 101. (1) 1.]

2. The licensee failed to comply with O. Reg. 79/10, s. 101 (2), as it relates to a verbal complaint made by complainant #76 and Residents #07, 53 and 08 by not ensuring that a documented record is kept in the home that includes:
(a) the nature of each verbal complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a

description of the response, and
(f) any response made by the complainant

Related to Log #O-001184-14, for Resident #42:

Complainant #76 contacted the ActionLine on a specified date voicing a concern as to the temperature in the home and its effect on complainant's loved one. Family indicated that concerns have been voiced to the Director of Care (DOC) and the home has not done anything about the concern.

The Director of Care indicated that a call was received by Complainant #76 regarding the heat once sometime last month. The DOC indicated a Client Feedback Form had not been completed as the call was not taken as a complaint but a concern. The DOC indicated that the home is sometimes warmer than usual but the heating system is older and difficult to regulate.

The Administrator and Environmental Services Manager indicated no awareness of this family's complaint.

Relating to Residents #07 and #53:

Residents #07 and #53 indicated reporting complaints to the management and or nursing staff, relating to a) their room being cold, especially the washroom and; b) that two residents across the hall cry all night long. Residents indicated these are long standing complaints without resolution. Residents indicated they have stopped voicing concern as their complaints go unheard. It was also noted that the vent in bathroom has been covered with cardboard and masking tape; On a specified date residents indicated staff had covered the vent.

The ESM indicated that Residents #07 and #53 frequently complain of their rooms being cold but when investigated the ESM finds the window open; ESM indicated no awareness of the vent in the room being covered with cardboard and masking tape.

Staff # 102, who works on the resident home area where Resident #07 and #53 resides, indicated being aware of the resident's concerns about the two residents crying or frequently calling out, indicating the (responsive) behaviour is normal for the residents.

The DOC indicated no awareness of the complaints by Resident #07 and #53 re: residents crying all night, but did indicate the concern would be addressed with Resident Care Area Manager.

Relating to Resident #08:

Resident #08 indicated voicing several complaints to the management team during a care conference on a specified date; resident indicated voicing the following complaints, a) the drapes in the resident's room had not been cleaned in over two years, b) when resident rings call bell for assistance, staff enter the room, cancel the call bell and indicate they will get someone to assist; resident indicated staff rarely return; and c) referred to an incident where resident asked for assistance in returning to room and staff shouted I'm busy helping residents on a specified unit, I'm not assigned to your unit, you will need to ask someone else to assist you. A progress note in resident #08's health record indicated that Staff #124 completed a Client Feedback Form following the conference.

The DOC indicated no awareness of Resident #08's concerns which were voiced at the annual care conference held on a specified date, despite Staff #124 indicating in the progress notes that a Client Feedback Form had been completed. Both the Director of Care and Director of Quality had no record to a form being completed. The Director of Quality indicated that Staff #124 can not recall if a form had been completed.

A review of the home's Client Feedback Forms 2014 binder (complaints log) for a 4 month period failed to provide any supporting documentation that the complaints voiced by Resident #07, 08, 53 and Complainant #76 were recorded on the Client Feedback Forms as indicated in the home's policy (Complaint Handling Process, ADM-QUA-100) nor is there any supporting records indicating the management of the home responded to the complainants.

The home's policy, Complaint Handling Process (ADM-QUA-100) directs that a Client Feedback Log is to be completed by any person receiving a concern or complaint. The policy communicates that it is the responsibility of the person receiving a concern or complaint to document the information on the Client Feedback Log Form, if follow up is required; identifying actions taken or recommended actions and names of persons accountable for these actions. The completed form is to be submitted to the Administrator.

The policy indicates that resident, family and visitor concerns are to be addressed promptly in an efficient manner and that client satisfaction is evidenced.

The Administrator indicated not being aware of any of the above concerns, despite resident's and family indicating concerns were voiced to the management team and asked that inspector addresses these concerns to others on the management team. [s. 101. (2)]

3. The licensee failed to comply with O. Reg. 79/10, s. 101 (3), by not ensuring that complaints received are reviewed and analyzed for trends at least quarterly and that the results of the review and analysis are taken into account in determining what improvements are required in the home.

The Administrator indicated, in an interview on November 03, 2014, that the Admission's Coordinator tracks all complaints and completes trending and analysis; the Administrator indicated that trending and analysis of complaints is completed but was unsure how often and commented complaints are to be reviewed at quarterly Leadership meetings but this has not been consistently occurring over the past year.

The Admission's Coordinator indicated being recently assigned the role of grouping complaints into categories (e.g. communication, lost money, clothing or property, resident issues, food issues, etc.) but indicated the management team has not yet utilized the information to determine trends occurring nor has information been used in determining improvements required in the home. The Admission's Coordinator indicated that this is a new process for the home and has not been completed on a quarterly basis.

The home's policy, Complaint Handling Process-Client Feedback Log (ADM-QUA-100) directs that the Administrator will complete the Client Feedback Log Summary Log on a monthly basis and will provide a summary of all Client Feedback Logs for the previous month to the Leadership/Partnership Team.

The policy further directs that the client feedback summary (monthly) is to be utilized for identifying trends, risk problems, and recommendations. [s. 101. (3)] (554)

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

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

Feb 02, 2015

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to achieve compliance with O. Reg. 79/10, s. 229.

The licensee shall ensure the plan includes:
- a review of infection control program and related policies to ensure staff are aware of their roles and responsibilities within the program and in mitigating risk of transmission of infections
- education for all staff relating to infection control including but not limited to, modes of transmission, use of personal protective equipment, and hand hygiene
- a process to monitor the effectiveness of infection prevention and control education
- measures to be taken when non-adherence to infection control policies, practices and procedures are identified

The plan shall be submitted in writing and emailed to Inspector, Amber Moase at amber.moase@ontario.ca on or before January 30, 2015. The plan shall identify who will be responsible for each of the corrective action listed.

Grounds / Motifs :

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

The following observations were made:

- Staff #117 was observed, on a specified date, cleaning a specified room; staff was observed not wearing personal protective equipment (PPE), despite signage on the door indicating Contact Isolation/Precautions. Staff #117 indicated being told by Registered Nursing Staff that PPE's were not required. It is noted that this is a shared resident room.

- Staff #118 was observed, on a specified date, cleaning room a specified room; staff was observed not wearing personal protective equipment (PPE), despite signage on the door indicating Contact Isolation/Precautions. During this same observation, Staff #118 had the housekeeping cart inside of the room. Staff indicated that the residents residing in the room were not contagious and that PPE's were not required when

cleaning the room. It is noted that this is a shared resident room.

- On a specified date, two nursing staff were observed caring for a resident in bed, in a specified room; staff were not seen wearing personal protective equipment (PPE), despite signage on the indicating Contact Isolation/Precautions.

The home's policy, Isolation - Daily Cleaning (HKG D-10-05) directs that the Housekeeping Aide is to gown and glove at entrance of isolation rooms prior to cleaning.

The ESM indicated that Housekeeping Staff are to wear personal protective equipment (gown, gloves, ect.) at all times when cleaning rooms with signage indicating Contact Precautions /Isolation or any other infection precautionary signs. The DOC and ESM confirmed that the Registered Nursing staff had provided improper direction to the staff regarding the PPE.

The ESM confirmed that both Staff #117 and #118 had annual education specific to infection control, which included cleaning and disinfection and additional precautions / use of PPE's; training was completed May and June 2014.

The DOC, who is the lead for infection control, indicated that staff providing direct resident care and/or housekeeping staff cleaning resident rooms are to wear the indicated PPE when any resident is designated as being in isolation or infection precautions. The DOC further indicated that housekeeping carts are not to be in resident rooms, but are to be in the hallway outside the room.

Other Observations on a specified date:

- Staff #105, who was working Linden Home Area, was observed administering medications during the noon medication pass; staff was observed administering medications to three residents, including once administering insulin without performing hand hygiene before or after any of the three residents.

- Staff #124, who was working Maple Resident Home Area, was observed administering medications during the noon medication pass; staff was observed administering medications to three residents without performing hand hygiene before or after any of the three residents.

The DOC indicated that all staff are provided infection control education upon hire and annually; education includes, 4 Moments of Hand Hygiene. The DOC indicated it is the expectation that all staff perform hand hygiene before and after contact with all residents. [s. 229. (4)] (554)

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

May 22, 2015

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007 s. 19 (1) to ensure all residents are protected from abuse and or neglect.

This plan shall include :
-a revised Zero Tolerance of Abuse and Neglect policy to identify the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation.
-a system to monitor and evaluate staff adherence to the Zero Tolerance of Abuse and Neglect Policy.
-a system to monitor and ensure that all staff complete the Licensee's retraining requirements at times or at intervals provided for in the regulations.

-The development and implementation of a monitoring process to ensure that:
- the resident's SDM is immediately notified of every incident of alleged, suspected or witnessed incident of abuse and are notified with 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.
- the Director is immediately notified if there are reasonable grounds to suspect the 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.
-the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.
-that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated and appropriate action is taken: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff
-the plan should also identify who is responsible for ensuring the completion of each and every item listed above.

The plan shall identify the time line for completing the tasks

The plan is to be submitted to Amber Moase by February 2, 2014 via email to amber.moase@ontario.ca

Grounds / Motifs :

1. 1. The licensee has failed to ensure that Residents #8, #15, #30, #29, #42, #16, #50, #57, #55 are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Emotional Abuse Definition
Under O.Reg.79/10, s.2(1)(a) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Related to Resident #8
During stage one of the RQI:
-Interview of Resident #8 (by Inspector # 554) stated they "had a confrontation with a staff member, and at the time, I hurt my arm, had to use manual chair, and they left me in the dining room. I asked staff member "Can you take me back? I had to ask several times". Staff responded "I'm looking after Maple not Birch, get someone else." Review of the progress notes for Resident #8 indicated during the care conference on a specified date, the home was notified of the resident’s concern of neglect of care and indicated a "client feedback form was completed” at that time. There was no documented evidence a “client feedback form” was completed at that time or an investigation into the allegation completed. A “Client Feedback” form was provided to the inspector by the DQN indicating Resident #8 had been re-interviewed and identified the staff member involved in the allegation of staff to resident neglect as PSW #136 but the staff member had not yet been interviewed. Review of the staff schedule for PSW#136 indicated the PSW worked 6 evening shifts since the home becoming aware of the incident.

Review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures states:
- If an employee(s) is involved, immediately notify of the pending investigation requiring alleviation from duty pending completion of the investigation, including reporting requirements to the Director (MOHLTC) and local police authorities.
- Immediately remove the persons allegedly or suspected of inflicting abuse from the immediate area and any resident home area, pending further investigation
-the Registered staff will report the alleged, actual, or suspected abuse to the Administrator, General Manager, Director of Care, Wellness Coordinator, and or designate, local police authorities, and the Director (MOHLTC).

- registered nursing staff and the person discovering the abuse shall prepare a written incident report. The report shall include: what occurred, when it occurred, who was involved, names of witnesses, where it occurred, what was observed and heard. The report shall be submitted to the Administrator, Director of Care and or designate.

Related to Resident #29
- Resident #29 stated during an interview on a specified date that "I had an earache and reported it to the RPN who told me the doctor would be in tomorrow to assess. The following day I saw the physician but he did not come to see me. A week later, the physician came in to see me and I stated I still have the earache and the physician said very loudly and abruptly to me "do you realize people die here". I just wanted my ear ache dealt with but I didn't like that." On a specified date the Administrator was notified of the allegation of physician to resident emotional abuse towards Resident #29. Review of the homes investigation indicated on a "client feedback log", dated the day the home became aware of the incident, the resident was interviewed and confirmed what was reported to the inspector. The form indicated under further action: "speak to Dr." to be completed by Administrator and DOC. There was no indication the physician was interviewed as of 7 days later and the physician had been in the home on 4 occasions since the home becoming aware of the incident.

There was no documented evidence that when the allegations of staff to resident abuse/neglect for Residents #8 and #29 were reported to the Administrator on the dates specified, that the Administrator completed the resident incident report as indicated in the home's policy as "the person discovering the abuse". The progress notes and plan of care were not updated regarding the allegations, as well as interventions to prevent recurrence and no indication that the substitute decision makers of the residents were notified of the allegations.

Review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures states:
- registered nursing staff and the person discovering the abuse shall prepare a written incident report. The report shall include: what occurred, when it occurred, who was involved, names of witnesses, where it occurred, what was observed and heard. The report shall be submitted to the Administrator, Director of Care and or designate.
- Immediately remove the persons allegedly or suspected of inflicting abuse from the immediate area and any resident home area, pending further investigation
-the Registered staff will immediately notify the Resident's substitute decision maker,

if any and any other person specified by the Resident, and they are to be notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a Resident

The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA, 2007 s. 23.(1)a Every licensee of a long-term care home shall ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff (Refer to WN#16)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

Verbal Abuse Definiton
Under O.Reg.79/10, s.2(1) (a) defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Related to Resident #15
-Interview of Resident #15 on a specified date "a staff member yells at him/her and is rude". The Administrator was notified of the allegation on October 30, 2014. The DQN indicated becoming aware of the allegation of staff to resident abuse on approximately 3 days later and initiated the investigation 2 days afterwards using the "client feedback forms". The DQN was not aware a "Resident Incident Report" was to be completed for allegations of abuse instead of a "Client Feedback Form". Review of the "client feedback form" provided by the DQN on a specified date indicated that PSW #134 was the alleged staff member involved in the incident and was to be interviewed by the DOC. The DQN indicated only the resident had been interviewed regarding the allegations. There was no indication that any of the staff had been interviewed or notified of the allegation or any other actions taken 4 days after the

allegation was reported to the home by the Inspector. Review of the staff schedule indicated that PSW#134 had worked day shift on three occasions since the home becoming aware of the incident.

Review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- Immediately remove the persons allegedly or suspected of inflicting abuse from the immediate area and any resident home area, pending further investigation.
-The Registered Staff and the person discovering the abuse shall prepare a written incident report. All documentation of an alleged, actual, or suspected abuse incident will use descriptive and precise language free from opinion and conjecture. The report shall contain the following information and shall be submitted to the Administrator, General Manager, Director of Care, Wellness Coordinator and/or designate: what occurred, when it occurred, who was involved (including the names of witnesses or those who were in the vicinity when it occurred), what was observed/heard, written statements from witnesses including information pertaining to the incident.
-the Registered staff will immediately notify the Resident's substitute decision maker, if any and any other person specified by the Resident, and they are to be notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a Resident.
The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

Related to Resident #30
-Interview of Resident #30 stated "a couple of weeks ago, a staff member was yelling at me in the morning when they were washing my face but I don't know their name". On a specified date the Administrator was notified of the allegation of staff to resident verbal abuse towards Resident #30. Review of the health care records for Resident #30 had no documented evidence that the SDM, or any other person specified by the resident were notified of an alleged incident of verbal abuse. Review of the "Client

Feedback" form provided by the DQN indicated 5 days after the home becoming aware of the incident, the resident was interviewed by the DQN and indicated PSW #137 was the staff member allegedly involved in staff to resident verbal abuse. The form indicated staff member had not yet been interviewed regarding the allegation. Review of the PSW schedule indicated that PSW #137 worked day shift on 5 occasions since the home becoming aware of the incident.

Review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- Immediately remove the persons allegedly or suspected of inflicting abuse from the immediate area and any resident home area, pending further investigation.
-The Registered staff will immediately notify the Resident's substitute decision maker, if any and any other person specified by the Resident, and they are to be notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a Resident.
The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

There was no documented evidence that when the allegations of staff to resident abuse/neglect for Residents #15 and #30 that were reported to the Administrator on specified dates, that the Administrator completed the resident incident report as indicated in the home's policy as "the person discovering the abuse" . The progress notes and plan of care were not updated regarding the allegations, as well as interventions to prevent recurrence and no indication that the substitute decision makers of the residents were notified of the allegations.

Related to Resident #16:
The home's former Director of Care, submitted a Critical Incident Report on a specified date. The CI details an incident of Staff to Resident (verbal) abuse, which was said to have occurred 2 days earlier; details of the incident are as follows:
- Staff #119 was asked by Resident #16 to make resident's bed; Resident #16 called

staff 'a lazy bitch'. Staff #119 responded 'I'm not a bitch, you are the bitch'.
The allegation of Staff to Resident (verbal) abuse was reported by the Registered Practical Nurse (#124) to the Resident Care Area Manager (RCAM #123), who was the supervisor in the home during the incident which occurred.
According to the CI report, the RCAM contacted the Director of Care of the incident. The incident of Staff to Resident Verbal Abuse was not reported to the Director within the time line required under legislation.

A review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- the Administrator, Director of Care and or designate will immediately report the incident to the Director (MOHLTC) and local police authorities.

The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA 2007 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: 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. (Refer to WN #17)

Related to Log #O-000584-14 for Resident #50
A critical incident, submitted, by the home's former Director of Care, on a specified date describes an incident of alleged Staff to Resident (verbal/physical) abuse reported to have occurred 1 day earlier.
Details of the CI are as follows: According to a Critical Incident Report Resident #52 reported hearing a staff member yelling at Resident #50 in the hallway sometime during the night; Resident #52 reports hearing staff yell at Resident #50 to go back to bed and then reports hearing a slapping sound followed by a yelping sound from Resident #50. According to the CI report, Resident #52 reported the incident to family; in turn, Resident #52's family reported the incident of verbal/physical abuse to Resident Care Area Manager (RCAM #123).

Director of Care indicated that Resident #52 has since deceased but was cognitively well when the incident was reported.

The current DOC indicated that there were three staff (a Registered Practical Nurse and two Personal Support Workers) assigned to work the night shift, on Resident #50 and #52's home area, on the date in question. The DOC indicated not being involved with the staff interviews, and deferred further comments to the Director of Quality. Director of Quality-Nursing stated that he and the former Director of Nursing interviewed the three staff as to the allegation of Abuse; Director of Quality indicated Staff #120, 121 and #122 were not interviewed as to the allegations until 7 and 8 days after becoming aware of the incident.
A review of the home's Staffing Assignment Schedule for a specified period, indicated that Staff #120, 121 and #122 worked shifts following the allegation and prior to being interviewed by the licensee or its designate on dates indicated above.

The Director of Quality could not comment as to why there was a delay in investigating the incident of alleged Staff to Resident Abuse. The Director of Quality commented the investigation as to the allegation of abuse was completed on a specified date and findings were inconclusive.
The Director of Quality indicated that the practice of the home is to immediately investigate all allegations of suspected or witness abuse and that during the investigation, staff alleged to be involved are normally placed on a leave of absence pending the outcome of the investigation.
The DOC and Director of Quality both indicated the allegation of abuse (verbal/physical) was not reported to the police. The Director of Quality, who was present during the investigation of the abuse, indicated the incident was not reported to the police as Resident #50 was assessed by registered nursing staff and found to have had no visible injuries nor could resident recall the incident.

A review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- Immediately remove the persons allegedly or suspected of inflicting abuse from the immediate area and any resident home area, pending further investigation.
The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- O. Reg 79/10 r. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may

constitute a criminal offence. O. Reg. 79/10, s. 98 (Refer to WN #23)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

Related to Resident #42
Complainant #76 contacted the home on a specified date and time, to report that Resident #42 had asked a staff member to turn off the television, as remote control was not within resident's reach; complainant indicated that a staff member stated, to the resident, "I'm not your bloody slave". Complainant indicated being concerned as to the way his/her loved one is being treated in the home when family is not around. Resident #42, during an interview on a specified date, indicated feeling belittled by the comment of staff; resident further commented 'I can't wait to get out of this place'.

Complainant #76 stated the concern surrounding verbal abuse was brought to the attention of Registered Practical Nurse #148, who was the Charge Nurse, working on Resident Home Area that day.
Staff #148 commented during an interview on a specified date, that the allegation of verbal abuse was brought to the attention of the Registered Nurse Supervisor, who was in charge of the home, on the date of the incident.
Staff #148 indicated that MOHLTC was not contacted as to the allegation of verbal abuse, as that is not staff's role, but a supervisor's job.

Resident Care Area Manager (#145) indicated awareness of the allegation but commented such was not reported to Director. The DOC indicated no awareness of Complainant #76's allegation of verbal abuse. The Administrator indicated that all staff are to report allegations of Abuse. The RCAM #145 stated during an interview on a specified date that the resident was not spoken to following the incident. Staff #148, RN supervisor and RCAM #145 all indicated they did not contact the resident's substitute decision maker following becoming aware of the incident. Staff #148 spoke with only two of the three staff working on the day of the incident.

A review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- If an employee(s) is involved, immediately notify of the pending investigation requiring alleviation from duty pending completion of the investigation, including reporting requirements to the Director (MOHLTC) and local police authorities.

-The Registered Staff and the person discovering the abuse shall prepare a written incident report. All documentation of an alleged, actual, or suspected abuse incident will use descriptive and precise language free from opinion and conjecture. The report shall contain the following information and shall be submitted to the Administrator, General Manager, Director of Care, Wellness Coordinator and/or designate: what occurred, when it occurred, who was involved (including the names of witnesses or those who were in the vicinity when it occurred), what was observed/heard, written statements from witnesses including information pertaining to the incident.
-the Registered staff will immediately notify the Resident's substitute decision maker, if any and any other person specified by the Resident, and they are to be notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a Resident.
The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA 2007 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: 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. (Refer to WN #17)
As of November 6, 2014, the Director of Care was investigating the concern of Complainant #76.

O.Reg. 79/10, s.2(1)(b) defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or staff member.

Log #00051 related to resident #57:
Review of the progress notes for Resident #54 indicated:
-on a specified date Resident #54 was found in his/her room with door closed and Resident #57 in the room. Staff removed Resident #57 from the room and Resident #54 followed them out of the room as well. Resident #54 then sat with Resident #57 at the nursing station and was observed with "his/her hands on Resident #57's private area and when the PSW attempted to separate them the resident hit the PSW on the hand" Resident #57 was taken to his/her room. Interview of the DOC

indicated the incident was not reported to the Director.
Review of the current care plan for Resident #54 indicated the resident is diagnosed with Dementia, is independently mobile, and demonstrates specified responsive behaviors. Strategies to deal with the responsive behaviors are specified in the care plan.

The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA 2007 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: 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. (Refer to WN #17)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

Related to Resident #55
A Critical Incident Report (CIR) was submitted by the home on a specified date for a resident to resident sexual abuse incident that occurred on a specified date. The CIR indicated Resident #55 was seen walking with a PSW towards own room and "was crying uncontrollably". When CN ask resident why the resident was crying, the resident stated that Resident #54 was sitting on a chair across from him/her at the nursing station when Resident #54 reached over and placed his/her hand between the resident's legs, touching his/her private area and then touched his/her self. The CIR had no indication that police were called.
Review of the progress notes for Resident #54 from a specified date range indicated:
-on a specified date the resident was observed “displaying inappropriate sexual behaviour towards another resident”. The PSW observed the resident inappropriately touch another resident. There was no indication which resident and no documented evidence of an investigation.
-on a specified date staff overheard voices in the residents room and when entered the room, found another resident laying in the resident's bed. The resident was distracted while staff removed the other resident from the room. There was no

incident report completed and no indication who the other resident was.
-on a specified date the resident was found in his/her room with door closed and Resident #57 in the room. Staff removed Resident #57 from the room. The resident followed them out of the room and then sat with Resident #57 near nursing station. The resident was then observed inappropriately touching Resident #57 and when the PSW attempted to separate them the resident hit the PSW on the hand" Resident #57 was taken to his/her room. The POA of resident was not notified of incident.

Review of the homes investigations and interview of staff indicated there was no investigations completed related to witnessed or suspected incidents of sexual abuse that occurred on the identified dates.
Review of the progress notes for Resident #55 and Resident #54 on a specified date had no indication the police were notified. Interview of the DOC indicated that if it was not indicated on the CIR then they were not notified.

The licensee failed to comply with:
- O. Reg 79/10 r. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98 (Refer to WN #23)
- LTCHA, 2007 s. 23.(1)a Every licensee of a long-term care home shall ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff (Refer to WN #16)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

In addition to the individual incidents and the areas of non-compliance identified for the incidents involving Residents #8, #29, #15, #30, #16, #50, #42, #57, #55, the following was also identified:

The licensee failed to comply with O. Reg. 79/10, s. 101(2), as it relates to a verbal complaint made by complainant #8 by not ensuring that a documented record is kept in the home that includes:
(a) the nature of each verbal complaint

(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant (As identified in WN #1)

The licensee failed to comply with LTCHA, 2007, s. 76(4), by not ensuring that all staff have received retraining annually relating to the following:
• The Residents' Bill of Rights
• The home's policy to promote zero tolerance of abuse and neglect of residents
• The duty to make mandatory reports under section 24
• The whistle-blowing protections (As identified in WN #19)

The licensee has failed to comply with O. Reg 79/10 s. 96. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, (d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation. (As identified in WN #21) [s. 19. (1)] (111)

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

Apr 20, 2015

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:

1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided.
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided.
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount.
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Order / Ordre :

The licensee shall ensure that residents in preferred accommodation are not charged more than what can be charged for basic accommodation unless the preferred accommodation was provided under an agreement.

The accommodation rate for Resident #44 shall be reviewed for a specified 19 month period. Resident #44 shall be reimbursed for any charges that exceed the preferred semi-accommodation rate as outlined in the admission agreement dated March 16, 2010.

The home shall also conduct an audit to ensure all residents paying a preferred accommodation rate have a signed agreement indicating consent to such charges.

Grounds / Motifs :

1. Related to Log #000146:

The licensee has failed to ensure that residents in preferred accommodation are not charged more than what can be charged for basic accommodation unless the preferred accommodation was provided under an agreement.

A complaint was received from the SDM of Resident #44 indicating on a specified date in 2012 the resident was transferred from a semi-private room to a private room and the SDM was not made aware of the transfer until after the resident was transferred. A review of the progress notes from a specified date range in 2012 for Resident #44 indicated the resident was transferred from one unit on a specified date in 2012 to another unit and there was no indication the SDM was notified.

The complaint submitted by the SDM of Resident #44 also indicated being overcharged for accommodations at a rate that was not agreed to in the admission agreement. Review of Resident #44's admission agreement indicated the resident was admitted into semi-private accommodation room/rate on a specified date in 2010. There were no other accommodation agreements in place.

Review of the resident's charges for accommodation indicated the resident was admitted on a specified date in 2010 at semi-private rate. The resident remained on semi-private rate (along with annual increases in July of each year) until a specified date in 2012 when the monthly accommodation charge was increased to private accommodation rate. The private rate was charged until a specified date in 2014 when the accommodation charge was changed to a basic accommodation rate. The SDM requested the funds be reimbursed.

Interview of the Administrative Assistant (AA) indicated she was given verbal direction by the previous DOC during a specific month of 2012 to change Resident #44's accommodation rate from semi-private to private rate as the resident was moved to a private room from a semi-private room. The AA indicated she did not complete a new accommodation agreement or contact the family regarding the new rate change. The AA indicated on a specified date in 2014 she received an email from the Administrator that the resident's rate was to be reduced to basic rate and the accommodation rate was changed. [s. 91. (1) 2.] (111)

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

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

Apr 20, 2015

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that:

- Education will be provided to Personal Support Workers in using safe transferring devices or techniques when assisting residents.
- Mechanical lifts, are kept in good repair, and maintained at a level that meets manufacturer specifications, at a minimum.

Grounds / Motifs :

1. Related to Log #O-001202-14

The licensee has failed to ensure that staff use safe transferring devices or techniques when assisting residents.

Resident #49's progress notes were reviewed. On a specified date, RPN #141

documented that 2 staff were transferring Resident #49 from bed to wheelchair by a full mechanical lift (ergo). During the transfer, the resident was on the sling up in the air over the wheelchair and the mechanical lift tilted entirely with the sling backward. The resident was over the wheelchair and landed on it, no injury was noted. Resident Care Manager (RCAM) and maintenance were notified and the lift was taken to be repaired.

On November 6, 2014 interview with RPN #141 indicated that on the date of the incident, two PSWs were transferring Resident #49 from bed to wheelchair when the whole lift tilted entirely backwards with the resident. The lift had a defect or a problem and could not tell what was wrong with the lift. RPN #141 indicated that the expectation is that PSWs should have checked the lift before use. An out of order sign was placed on the lift after the incident.

During an interview with PSWs #108, #142 and #143 they indicated that lifts are checked if working properly before use. The lifts are checked for charged batteries, proper sling, make sure the lift is clean, check arms if moving up and down and legs moving in and out, check if lift is easy to move, check sling is clean and not damaged. If a problem noted the nurse is informed, requisition is completed on computer and out of order sign will be placed on lift.

On a specified date and time, interview with Environmental Services Manager (ESM) indicated that lifts are inspected on monthly basis for preventative maintenance. The lifts are checked for the up and down and legs for out and close. If the lift is defective it will be removed for repair.

Review of a note by maintenance staff #144 indicated that an Ergo lift was tagged out of service and removed for inspection by maintenance on the date of the incident, after the incident occurred. A note by ESM indicated that the lift was tagged out in the maintenance shop from the date of the incident and a request for inspection was sent to Arjohuntleigh 15 days later.

Review of Arjohuntleigh service call report indicated the Ergo lift Maple #3 serial number ERLI-1887 which was used on the date of the incident, was inspected and found that the legs were loose and not aligned properly. The lift was repaired and technician suggested the some parts of the lift to be replaced including: 1 braked caster, emergency stop switch, hanger bar cover and pin assembly. The recommended parts were replaced.

There is no documented evidence that the Ergo lift Maple #3 serial number ERLI-1887 was inspected to be in good repair and safe for use prior to the incident by maintenance staff or by PSW staff prior to use with Resident #49. There was no maintenance record of this lift prior to the date of the incident and there was no documentation the lift was checked monthly similar to other lifts in the home as it was not included in the assets inventory of the home. [s. 36.] (570)

2. Related to Log #O-001255-13

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

A Critical Incident indicated that on a specified date PSW #128 was getting Resident #46 dressed out of bed for lunch. Resident was sitting upright at side of bed. PSW #128 turned around to get wheelchair and Resident #46 fell forward onto the floor sustaining an injury that required sutures at hospital.

Review of Resident #46's plan of care related to transferring and Falls/Balance indicated the resident requires extensive assistance – two + persons physical assist and the resident's risk of falls is high related to history of falls, unsteadiness, and self transferring but too weak to do so.

Resident #46's progress notes were reviewed. On a specified date, RPN #131 documented that Resident #46 fell from bed and sustained an injury. The resident was unconscious for a few minutes.

On a specified date, interview with PSW #128 indicated at the time of the incident, PSW#128 assisted Resident #46 to dress up and sat him/her up at edge of bed. Resident's feet at the time were not entirely flat on the floor. PSW #128 was aware of resident's transfer status of 2 persons assist and was waiting for another staff member to help. The resident fell, while PSW #128 was reaching over to pull the wheelchair and could not prevent the resident from falling.

On a specified date, interview with DOC indicated at the time of the incident, a bang was heard from Resident #46's room and found Resident #46 on the floor. The DOC indicated that PSW #128 should have not left Resident #46 sitting at edge of bed as the resident could not maintain upright sitting position and requires two persons assist for transfer.

An internal investigation completed by the home confirmed that PSW #128 had failed to use safe transferring techniques when the resident was left sitting at the edge of bed, unsupported. [s. 36.] (570)

3. Related to Log #O-000500-14

The licensee has failed to ensure that staff use safe transferring techniques when assisting residents

A Critical Incident indicated that on a specified date while PSW #127 and PSW #110 were transferring Resident #46 from bed to wheelchair using a mechanical lift, the resident fell out of the sling onto the floor approximately 4 feet to the ground, sustaining an injury.

Resident #46's progress notes were reviewed. On the date of the incident, RPN #124 documented that PSWs on Pine unit were transferring Resident #46 from the bed to the wheelchair using a mechanical lift. During the transfer, Resident # 46 fell from the sling and sustained a skin tear. Sling used for transfer was blue with red boarder (Arjohuntleigh Article Num MAA4100m-s). No visible deficit was noted on sling all four clips were present and intact.

On a specified date interview with PSW #127 indicated at the time of incident the left hook snapped and had no idea how that happened. PSW #127 was operating the lift when PSW #110 was coming around. The hook was not broken, it was just snapped. PSW #127 stated "I should pay more attention".
On November 6, 2014 interview with PSW #110 indicated at time of incident he/she was assisting staff #127 to transfer Resident #46. PSW #110 hooked up the left side and checked it and PSW #127 hooked up the other side. While Resident #46 was lifted, the left hook came off causing the resident to slide down and roll to the floor. PSW #110 was not guiding the resident when the resident fell. PSW #110 was coming around to direct the resident to the chair.

A written statement by PSW #110 on the date of the incident indicated that while helping a staff member to transfer Resident #46 from the bed to the wheelchair, the resident slid out of the sling onto the floor.

A written statement by PSW #127 on the date of the incident indicated that while getting Resident #46 up from bed with my partner, we used the full lift that we were supposed to use. When lifting the resident up, the sling at the left side snapped and the resident slid out of the sling and fell.

An interview with DOC on a specified date indicated that, she was called to unit and found Resident # 46 on the floor. The DOC confirmed that PSW #127 and PSW #110 did not follow policy of operating the mechanical lift to ensure the resident is safe during the transfer. One PSW forgot to clip his/her side of the sling and the other PSW started to operate the lift while his/her partner was not ready to guide and reassure the resident during the transfer.

An internal investigation completed on a specified date by the home concluded that PSW #127 and PSW #110 had performed an improper mechanical lift which resulted in injury to resident.

The staff failed to ensure the Resident's safety during transfer. [s. 36.] (570)

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

Apr 20, 2015

Order # /
Ordre no : 006

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 :

Ontario

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

(A1)
The licensee shall ensure that, for Resident #54 demonstrating responsive behaviours, (a) the behavioural triggers for Resident #54 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.

The licensee shall ensure the care plan for Resident #54 clearly outlines the current strategies to manage responsive behaviors. The strategies will be reviewed with Resident #54 s health care team. The licensee shall ensure that any identified strategies for Resident #54 will be consistently implemented. When strategies developed for Resident #54 are deemed ineffective, the Resident will be reassessed and that assessment will be documented.

The licensee shall develop a monitoring system to ensure that strategies are developed and implemented to respond to responsive behaviors. This system shall include:
- Who is responsible to implement the strategies to responsive behaviors
- How long each strategy is to be in place
- When the resident will be re-assessed and who is responsible to complete the re-assessment

The licensee shall also ensure all staff on each shift are aware of each resident exhibiting responsive behaviors and the strategies in place to manage these behaviors

Grounds / Motifs :

1. Related to Log #000551:

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

Review of the current care plan for Resident #54 indicated the resident is diagnosed with cognitive impairment, is independently mobile, and demonstrates specified responsive behaviours and specified strategies to manage the responsive behavior.

Review of the progress notes over a 6 month period for Resident #54 indicated on specified dates and times 4 incidents where Resident #54 inappropriately touched another resident, 2 incidents where another resident was found in Resident #54's room without staff being aware, 3 incidents where Resident #54 attempted to hit or touch another resident but was stopped by staff. On one specified date Resident #54's monitoring was decreased from every 15 minutes to every 1 hour monitoring.

Interview of PSW #140 by Inspector #541 indicated that they are not currently monitoring Resident #54 as "his/her behaviours have calmed down". Observation of the resident's room by Inspector #541 indicated the specified interventions in Resident #54's care plan were not in place.

Review of the progress notes for Resident #54 indicated the resident demonstrated inappropriate sexually touching and sexual comments to several residents and staff. The resident also wandered into other resident's rooms and other residents wandering into the resident's room. The resident also displayed verbal and physical aggression towards staff and residents. The resident was placed on every 15 minute checks following the second incident of resident to resident sexual abuse.

The current care plan for Resident #54 indicated that some of the specified strategies suggested were not effective, but still in use and some of the specified strategies were not consistently implemented. Some of the specified strategies identified were not clear as to when they would be implemented. Some of the specified strategies to prevent sexually inappropriate responsive behaviour were not implemented. [s. 53. (4) (b)] (111)

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

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

Feb 09, 2015(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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 30 day of January 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : AMBER MOASE - (A1)

Service Area Office /
Bureau régional de services : Ottawa

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 12, 2015	2015_360111_0002	O-001311-14	Complaint

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road 3rd Floor PICKERING ON L1V 1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 19, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator

The following Inspection Protocols were used during this inspection:
Admission and Discharge

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

1 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

The licensee has failed to ensure that before discharging a resident under subsection 145(1), the licensee collaborated with the appropriate placement co-ordinator and other health service organizations, to make alternative arrangements for the accommodation, care and secure environment required by the resident.

On a specified date, Resident#1 was transferred to hospital on a Form 1 for psychiatric assessment. A complaint was received from the substitute decision maker(SDM) the same day as the SDM indicated the home had called to inform the SDM the resident was being discharged. The inspector interviewed the Administrator, Social Worker, and DOC who indicated the resident was initially discharged in error due to mis-communication. The SDM was then notified by the home that the resident was not discharged, just on psychiatric leave.

Twelve days later, an email was received by the Inspector from the SDM regarding a second complaint from the SDM indicating the home had submitted a letter(dated 7 days earlier)to the SDM discharging the resident(again). The resident was still in hospital on psychiatric leave. Review of the discharge letter had no indication the placement coordinator was contacted/consulted regarding the discharge.

The same day, the Administrator was contacted for an off-site telephone interview. The Administrator indicated the home consulted with psychiatric services and the Medical Director for the home regarding the resident's responsive behaviours and risk of injury to staff, and decided to discharge the resident. The Administrator indicated he contacted the placement coordinator to inform them the resident was being discharged. This did not demonstrate collaboration with placement coordinator for accommodation and or care, nor were the resident or the resident's substitute decision maker (s) given an opportunity to participate in the discharge planning process.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 12th day of February, 2015

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

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 30, 2015	2015_293554_0009	O-001244-14	Critical Incident System

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 09 -11, 2015

Inspection was specific to Intake #O-001244-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing Services (DONS), Director of Care (DOC), Director of Quality Nursing, Staff Educator, Resident Care Area Managers (RCAM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behavioural Support Staff (BSO), Housekeeping Staff, Physio Assistant, Dietary Aide(s), Residents, and Family.

During the course of the inspection, the inspector also reviewed health records for specific resident(s), reviewed the home's investigation documentation, reviewed critical incident report, reviewed staff education relating to Falls Prevention, and reviewed the home's policies specific to Falls Prevention and Management, Complaints, Responsive Behaviours

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Hospitalization and Change in Condition

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 6 (2), by ensuring the plan of care is based on an assessment of the resident and the resident's needs and preferences, relating to Falls Management.

Resident #01 has a diagnosis that includes cognition impairment. A review of the clinical health record indicates that resident has a known history of falls risk and is described as being at "extreme high risk for falls". The Health Care Directive for this resident, as expressed by resident's Power Attorney for Care is a Level 3, which indicated if there is a change in the resident's condition, resident is to be transferred to an acute care hospital.

According to the Critical Incident Report (CIR), Resident #01 had an unwitnessed fall on a specific date and at a specific time; Resident #01 was found on the floor in a pool of blood, with blood noted to extremities, night gown and the bedside drapes. The CIR, resident incident report and progress notes all indicated resident sustained substantial injuries, as a result of the fall.

Registered Practical Nurse #37, who was working at the time of the incident, indicated he/she had assessed Resident #01, noting the specific injuries; RPN #37 indicated cleansing and dressing the injuries post fall, and further indicated that RN #38, who was the supervisor on duty, did not assess the injuries prior to bandages being applied.

Progress notes and resident incident report, reviewed for a specific date, failed to provide evidence of RN #38 completing an assessment nor documenting specifics relating to Resident #01's fall, injuries or monitoring during the remainder of the shift. Director of Nursing Services confirmed that there was no documentation by RN #38.

Registered Practical Nurse #37 indicated he/she had communicated (via phone) to RN #38, supervisor on shift, that Resident #01's dressing had been changed twice post fall (and subsequent to the initial dressing), as the bandages had been saturated with blood, but was told, by RN #38, nursing supervisor on duty, to continue to monitor Resident #01. Registered Practical Nurse #37 indicated that he/she felt that Resident #01 needed to be transferred to hospital due to injuries sustained and amount of blood loss, but indicated Registered Nurse #38's directive was to monitor Resident #01 at the long term care home. RPN #37 indicated he/she disagreed with Registered Nurse's decision, but did not communicate this concern to any other Registered Nursing Staff nor the Director of Care.

Registered Practical Nurse #37 indicated that the physician was not notified of the fall and resulting injuries. Registered Practical Nurse #37 indicated he/she did not contact the physician as he/she was fearful of waking physician during the night and his/her direction from RN #38 was to monitor Resident #01. RPN #37 indicated he/she had communicated his/her concerns to RN #38.

Registered Nurse #38 indicated he/she had not communicated the incident with injury to the physician as he/she was not aware that Resident #01 had bruising nor continued blood loss from the injuries; RN indicated, Resident #01 was stable and did not need to be transferred to the hospital for medical treatment.

Resident #01 was assessed by the oncoming Resident Care Area Manager (shift supervisor), at which time, the family of the resident was contacted (approximately seven hours later) and a decision was made to transfer Resident #01 to hospital for assessment and treatment.

The home's policy Resident Safety-Falls Prevention (#RSL-SAF-055), directs Registered Nursing Staff to do the following for a Fall resulting in injury, notify the physician immediately if the resident has suffered an injury; in the absence of the physician, the registered nursing staff will exercise clinical judgement in calling 911 to arrange for transportation to the hospital.

Resident #01 was transferred to the hospital on a specific date, approximately seven hours post fall and treated for injuries sustained.

During this Inspection, a Critical Incident Report (CIR) was inspected, the CIR details Resident #01 having had an unwitnessed fall, on a specific date and at a specific time. Resident #01 sustained substantial injuries. Registered Practical Nurse indicated the bandages covering resident's injuries required changing twice due to blood saturating the dressing. Registered Practical Nurse #37 and Registered Nurse #38 both indicated the physician had not been notified of the fall and resulting injury. Resident #01 was not transferred to the hospital for assessment and treatment until approximately seven hours later, at which time, resident was treated for his/her injuries.[s. 6. (2)]

2. The licensee failed to comply with LTCHA, 2007, s. 6 (7), by ensuring the care set out in the plan of care was provided to the resident as specified in the plan, related to Falls Prevention and Management.

Resident #01 has a diagnosis that includes cognition impairment. Resident has been identified as a falls risk 'extreme high risk'. Resident #01 had falls in the previous year, which included, one fall incident that occurred on a specific date, which resulted in a Critical Incident Report being submitted due to, resident's fall resulting in substantial injury and need for hospital transfer, assessment and treatment.

Progress notes and incidents reports indicated Resident #01 has had five falls to date for the current year, one of which resulted in injury.

The Plan of Care (in place at time of inspection) indicates the following:

- Toileting – assistance required, includes transferring, hygiene and clothing adjustments. Interventions include, call bell to be within reach; staff to encourage resident to call for staff assistance; do not leave unattended on the toilet; one person physical assistance; staff to assist resident to use the toilet at specified times; staff to toilet resident every two hours during a specific shift; staff to accompany resident back from the dining room and toilet resident after all meals.

- Transferring – extensive assistance required. Interventions include, remind resident to request assistance before all transfers; bed sensor pad in place to prevent self-transfer; when alarm is sounding, staff to attend to alarm and transfer resident into chair.

- Walk in Room/Corridor – Interventions include, resident will be supported by staff when walking; will be returned to wheelchair when found walking in resident's room; ensure chair and bed alarm is on at all times and ensure alarm is in working order.

- Locomotion On and Off Unit – Interventions include, total assistance by staff; staff to push resident's wheelchair.

- Aids to Daily Living / Safety Devices – Interventions include, staff to porter resident to and from dining room; chair and bed alarm should be in place and attached to resident at all times; ensure chair alarm is transferred from wheelchair to bed when resident is resting; ensure bed and chair alarms are on and are working.

- Falls and or Balance – High Risk for falls. Interventions include, ensure call bell within reach at all times; ensure bed senor pad is on and working; resident to be monitored hourly; falls mat at bedside; resident to be toileted at specific times (indicated in plan of

care) by one staff; to be toileted every two hours on a specific shift; staff to respond to floor mat alarm as soon as hear alarm.

The following observations were made during a two day period, during this inspection:

- During the morning of a specific date (over a three hour time period) Resident #01's bed/chair alarms sounded eight separate times without staff intervening (alarm turned off on own). Resident #01 was seen returning from the washroom on at least one occasion without staff support. Staff were not observed entering the room to toilet Resident #01 despite scheduled toileting times.

- Resident #01 was observed in the dining room, on a specific date, during a scheduled meal time, resident's personal chair alarm was not attached to the resident or turned on.

- Resident #01 was observed on a specific date, self-propelling his/her own wheel chair, staff were not in attendance. Resident was seen wheeling self, down the hallway and was observed standing up in wheelchair, the chair alarm was not heard alarming; resident seated self safely back into the chair. A few minutes later, Resident #01 entered his/her room, the bed sensor mat was heard sounding, while a Registered Practical Nurse and two Personal Support Workers walked within the same vicinity as resident's room, without responding to the bed/chair alarm; the alarm was responded to by another Personal Support Worker.

Staff #30, assigned to care for Resident #01, indicated no awareness of the need for staff to accompany Resident #01 to and from the dining room, indicating resident is able to take self to and from meals. Staff #30 indicated that often the floor sensor mat isn't working, therefore, staff don't always know that resident has gotten out of bed and toileted his/herself. Staff #30 indicated no awareness of the need to transfer the chair alarm from wheelchair to bed while resident is resting.

Registered Practical Nurse #37, who supervises the resident home area during the night, indicates that staff do not toilet Resident #01 during the night as the unit is too busy and the toileting time expectations are unrealistic. RPN #37 indicated that often staff do not transfer the chair alarm to resident's bed, adding there are already two alarms on the bed, although the sensor floor mat is usually not working.

Resident Care Area Manager (RCAM), who supervise the home area where Resident #01 resides, indicated that he/she didn't think the chair alarm needed to be transferred

from wheelchair to bed while resident was resting, as Resident #01 already had two bed alarms in place; RCAM agreed it was an intervention listed in the plan of care. RCAM also indicated awareness that the floor sensor mat is often not working, indicating the home was looking into alternative equipment (e.g. alarms).

Resident Care Area Manager, Director of Care and Director of Nursing Services all indicated the plan of care for each resident is to be followed. RCAM and Director of Nursing Services both indicated Resident #01 remains at extreme falls risk and not following the plan of care places resident at risk of further falls and or potential injury.

A Critical Incident Inspection was conducted concurrently with this inspection. A Written Notification, for LTCHA, 2007, s. 6 (7) was included in Compliance Order #001, under LTCHA, 2007 s. 19 (1) was issued in an identified inspection. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 87 (2) (d), by ensuring that procedures are developed and implemented for addressing incidents of lingering offensive odours.

During the inspection dates of June 03-05, June 09-12 and June 15, 2015, a pervasive malodour was smelt throughout hallway on a resident Home area (RHA), in the front foyer, in the hallway by the managerial offices (near Executive Director and Director of Nursing Services) and in the hallway leading toward the main dining room (off of Maple RHA). The pervasive odour could be smelt continuously during the hours of approximately 08:30 hours through to the 14:30 hours, but was extremely noticeable from approximately 13:00 – 1430 hours. The offensive odour was noted during the above dates by Inspector #111 and #554.

A Housekeeping Aide working in the identified resident home area indicated that the lingering odour was not unusual for the home area. [s. 87. (2) (d)]

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 there is a process in place and monitored to ensure that incidents of lingering offensive odours are addressed and managed, to be implemented voluntarily.

WN #3: 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):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 107 (3) 4., by ensuring the Director was informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

The Director of Care submitted a Critical Incident Report (CIR) on a specific date, with regards to an incident that caused injury to a resident for which the resident was taken to hospital and which results in a significant change in the resident's health status. The incident was said to have occurred on a specific date.

The CIR outlines the following details:

- Resident #01 was found lying on the bedroom floor at a specific time, resident was alert but confused; resident was lying in and was covered in blood (to extremities, nightgown and bedside drapes). Resident #01 was assessed by registered nursing staff to have substantial injuries.

According to the CIR and progress notes (date of injury) Resident #01 was transferred to hospital for assessment and treatment.

Resident Care Area Manager indicated that the injury on a specific date, resulted in a significant change in resident's health status, which intern affected resident's ability to

participate in his/her activities of daily living, especially noting the injuries were to the resident's dominant extremity. RCAM indicated he/she did not contact the Director (MOHLTC) of this incident and further indicated no awareness of the need to contact the Director (MOHLTC) of this incident.

Director of Care (now Director of Nursing Services) indicated he/she thought he/she had contacted the Director (MOHLTC) of this incident, but had no evidence to support such contact.

Centralized Intake Assessment Triage Team (C.I.A.T.T) and Spills Action Centre (SAC) both indicated via email that neither the Director of Care nor any other member of the home had contacted them of the incident on a specific date; the first notification of this incident was two days later (post-incident). [s. 107. (3) 4.]

2. The licensee failed to comply with O. Reg. 79/10, s. 107 (5), by ensuring that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

Resident #01 has a diagnosis that includes cognitive impairment, and has had multiple injuries related to falls. Resident is indicated at being at high falls risk. Resident #01's Health Care Directive, expressed by resident and family is a Level 3, which indicates, resident is to be transferred to hospital if health condition changes.

Resident #01 had an unwitnessed fall on a specific date and time; Resident #01 was found lying in a pool of blood with blood noted to extremities, night gown and the bedside drapes. According to the Critical Incident Report, resident incident report and progress notes, Resident #01 sustained substantial injuries; injuries of Resident #01 were noted by Registered Practical Nurse.

Progress notes, dated on a specific date and time, indicated the family of Resident #01 was not notified of the fall with injury until approximately seven hours later (as per the Resident Care Area Manager), when a decision was made to transfer Resident #01 to hospital for assessment and treatment.

Resident was assessed and treated at hospital for injuries substained.

Interviews with Resident Care Area Manager (RCAM), Registered Practical Nurse and Director of Nursing Services (formerly Director of Nursing) all indicated the family of Resident #01 voiced displeasure at not being contacted by the long term care home sooner of the fall and resulting injury.

Director of Nursing Services and the Administrator, both indicated the expectation would be to immediately contact the substitute decision maker or other designate of a resident incident which resulted in injury, such would have been the expectation involving Resident #01's incident. [s. 107. (5)]

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 there is a process in place and monitored, ensuring the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified, 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 failed to comply with O. Reg. 79/10, s. 8 (1), by ensuring that any plan,

policy, protocol, procedure, strategy or system instituted or otherwise put in place, is complied with, specific to Falls Prevention and Management.

Under O. Reg. 79/10, s. 48 (1) 1, every licensee of a long term care home shall ensure that the following interdisciplinary programs area developed and implemented in the home, a falls prevention and management program to reduce the incidence of falls and risk of injury.

The home's policy Resident Safety-Falls Prevention (#RSL-SAF-055), directs Registered Nursing Staff to do the following for a Fall resulting in injury, notify the physician immediately if the resident has suffered an injury; in the absence of the physician, the registered nursing staff will exercise clinical judgement in calling 911 to arrange for transportation to the hospital; inform the Power of Attorney of the injury and transfer to hospital at the earliest convenient opportunity following immediate assessment and intervention; and the registered nursing staff will report to the Manager on Call and or the Director of Care immediately by telephone.

The clinical health record (progress notes, incident report) and Critical Incident Report (CIR) indicate Resident #01 had an unwitnessed fall on a specific date and at a specific time. Resident sustained substantial injuries; resident was placed on enhanced monitoring. Resident #01 was later transferred to hospital for assessment and treatment relating to injuries sustained.

The home's policy, Falls Prevention was not complied with as evidenced by the following:

- progress notes indicate, the family of Resident #01 was not notified of the fall with injury until approximately seven hours post fall on a specific date;
- progress notes, further, indicate Resident #01 was not transferred to the hospital until approximately seven hours later, despite substantial injuries, and blood loss;
- Physician was not contacted of the fall with injury, until approximately seven hours post-incident;
- Registered Practical Nurse #37 indicated he/she did not agree with Registered Nurse #38's decision not to send to Resident #01 to hospital, but did not communicate concerns to other registered nursing staff at the time of the incident nor Director of Care.
- Director of Care (now Director of Nursing Services) indicated he/she had not been notified of the fall with injury until the next business day, following the incident. [s. 8. (1)]

2. The home's policy, Falls Prevention and Management Program – Resident Quality

Indicators (#RESI-10-02-01) directs that the home will establish a flagging system to clearly identify to all staff the residents that area at high risk for falls (e.g. falling star, falling leaf or colour coded arm bracelets, etc.). The policy identifies that the Registered Nursing Staff are to initiate the flagging system for all high risk resident's for falls.

Resident Care Area Manager #25, who oversees the Falls Prevention and Management Program indicated that all staff were provided education specific to the new policy #RESI-10-02-01, specific to Falls Prevention and Management, during two specific dates, during this year, and that a collaborative decision was that all residents who were identified as being at 'high risk' for falls would be identified by wearing a green plastic bracelet. RCAM indicated that all staff are aware of the high falls risk identifier.

Resident #01 was observed during the dates during a specific period not wearing a green plastic bracelet on his/her arm (or on resident's wheelchair). Resident is indicated in his/her plan of care as being at extreme high risk of falls. There is no indication in the plan of care that resident was to wear a falls identification bracelet.

Staff #30, 31 and 34 all working on Resident #01's home area all indicated no awareness of green bracelets nor any other identification tool used by the home to identify those resident's being at high risk for falls. Staff #30, 31 and 34 all indicated receiving falls prevention and management education during a specific month, during the current year.

Resident Care Area Manger (RCAM) #25 and #26 both indicated Resident #01 was indicated as being at extreme high risk of falls and should be wearing a green bracelet to identify such. Resident Care Area Manager #26 indicated that Resident #01 may have removed the green bracelet; RCAM was unsure if staff knew Resident #01 removes the bracelet and were unsure if staff on the unit knew to check for the bracelet on a regular basis.

The Director of Nursing Services (DONS) indicated that the expectation is that all staff follow the home's policy and procedures, especially as such relates to Falls Prevention and Management. DONS indicated if the Resident Care Area Manager (and or other staff) were aware that Resident #01 removes the falls risk identification bracelet, then this should be noted in the plan of care and monitored. [s. 8. (1) (a),s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 103 (1), by ensuring that a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1).

Under LTCHA, 2007, 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 result in harm or a risk of harm to the resident.

The Director of Care (now Director of Nursing Services) indicated receiving a written correspondence (email) from the Family of Resident #01 on a specific date voicing displeasure and concern regarding care lacking following a falls incident, in which Resident #01 sustained substantial injuries.

The incident occurred on a specific date, and at a specific hour; resident's family was not notified until approximately seven hours later, at which time a decision was made to transfer resident to hospital for assessment. Resident was assessed and treated for substantial injuries and later returned to the long term care home.

The letter, written by the family of Resident #01, was reviewed by the inspector during this inspection, in the letter, the family questioned the care provided to Resident #01, during a specific time period and why there had been delay's in transferring resident to

hospital for assessment and treatment of injuries, specific to a falls incident.

Family indicated in the letter, written to the Director of Care, that the care their love one had received was unacceptable.

Director of Nursing Services (formerly Director of Care) indicated receipt of the letter from the Family of Resident #01 and stated that care provided to resident post-falls incident, on a specific date, was unacceptable and constituted improper care; Director of Nursing Services indicated registered nursing staff involved were provided re-instruction and discipline.

Director of Nursing Services (DONS) indicated that the letter from the Family of Resident #01 was not forwarded to the Director (MOHLTC). DONS commented that the letter from the family implied neglect of care, but indicated not being aware that the letter at the time should have been sent to the Director (Ministry of Health and Long-Term Care).

Administrator indicated no awareness of the letter from the Family of Resident #01, indicating if he/she knew of such, the letter would have been forwarded to the Ministry of Health and Long Term Care.

A Critical Incident Inspection was conducted concurrently with this inspection. A Written Notification, for O.Reg. 79/10, s. 103 (1) was included in Compliance Order #001, under LTCHA, 2007 s. 19 (1) was issued in the identified inspection. [s. 103. (1)]

Issued on this 11th day of September, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY BURNS (554)
Inspection No. / No de l'inspection :	2015_293554_0009
Log No. / Registre no:	O-001244-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 30, 2015
Licensee / Titulaire de permis :	CVH (No.6) GP Inc. as general partner of CVH (No.6) LP c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mona Babb

To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, 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.O. 2007, c.8, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The Licensee shall:

1) Review and update the plan of care for Resident #01 and all other residents who are at high risk for falls, to ensure the planned care is individualized and meeting the needs of the resident.

2) Implement measures and a monitoring process to ensure that the care set out in the plan of care, especially for those residents at high risk for falls, is followed, and that appropriate and timely action is taken when the needs of the resident(s) are not met.

3) Provide re-instruction to all registered nursing staff of the importance of following the home's policies, specifically, Falls Prevention and Falls Prevention and Management Program, especially when a resident is exhibiting a change in health status.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA, 2007, s. 6 (2), by ensuring the plan of care is based on an assessment of the resident and the resident's needs and preferences, relating to Falls Management.

Resident #01 has a diagnosis that includes cognition impairment. A review of the clinical health record indicates that resident has a known history of falls risk and is described as being at "extreme high risk for falls". The Health Care Directive for this resident, as expressed by resident's Power Attorney for Care is a Level 3, which indicated if there is a change in the resident's condition, resident is to be transferred to an acute care hospital.

According to the Critical Incident Report (CIR), Resident #01 had an unwitnessed fall on a specific date and at a specific time; Resident #01 was found on the floor in a pool of blood, with blood noted to extremities, night gown and the bedside drapes. The CIR, resident incident report and progress notes all indicated resident sustained substantial injuries, as a result of the fall.

Registered Practical Nurse #37, who was working at the time of the incident, indicated he/she had assessed Resident #01, noting the specific injuries; RPN #37 indicated cleansing and dressing the injuries post fall, and further indicated that RN #38, who was the supervisor on duty, did not assess the injuries prior to bandages being applied.

Progress notes and resident incident report, reviewed for a specific date, failed to provide evidence of RN #38 completing an assessment nor documenting specifics relating to Resident #01's fall, injuries or monitoring during the remainder of the shift. Director of Nursing Services confirmed that there was no documentation by RN #38.

Registered Practical Nurse #37 indicated he/she had communicated (via phone) to RN #38, supervisor on shift, that Resident #01's dressing had been changed twice post fall (and subsequent to the initial dressing), as the bandages had been saturated with blood, but was told, by RN #38, nursing supervisor on duty, to continue to monitor Resident #01. Registered Practical Nurse #37 indicated that he/she felt that Resident #01 needed to be transferred to hospital due to injuries sustained and amount of blood loss, but indicated Registered Nurse #38's directive was to monitor Resident #01 at the long term care home. RPN #37 indicated he/she disagreed with Registered Nurse's decision, but did not communicate this concern to any other Registered Nursing Staff nor the Director of Care.

Registered Practical Nurse #37 indicated that the physician was not notified of the fall and resulting injuries. Registered Practical Nurse #37 indicated he/she did not contact the physician as he/she was fearful of waking physician during the night and his/her direction from RN #38 was to monitor Resident #01. RPN #37 indicated he/she had communicated his/her concerns to RN #38.

Registered Nurse #38 indicated he/she had not communicated the incident with injury to the physician as he/she was not aware that Resident #01 had bruising

nor continued blood loss from the injuries; RN indicated, Resident #01 was stable and did not need to be transferred to the hospital for medical treatment.

Resident #01 was assessed by the oncoming Resident Care Area Manager (shift supervisor), at which time, the family of the resident was contacted (approximately seven hours later) and a decision was made to transfer Resident #01 to hospital for assessment and treatment.

The home's policy Resident Safety-Falls Prevention (#RSL-SAF-055), directs Registered Nursing Staff to do the following for a Fall resulting in injury, notify the physician immediately if the resident has suffered an injury; in the absence of the physician, the registered nursing staff will exercise clinical judgement in calling 911 to arrange for transportation to the hospital.

Resident #01 was transferred to the hospital on a specific date, approximately seven hours post fall and treated for injuries sustained.

During this Inspection, a Critical Incident Report (CIR) was inspected, the CIR details Resident #01 having had an unwitnessed fall, on a specific date and at a specific time. Resident #01 sustained substantial injuries. Registered Practical Nurse indicated the bandages covering resident's injuries required changing twice due to blood saturating the dressing. Registered Practical Nurse #37 and Registered Nurse #38 both indicated the physician had not been notified of the fall and resulting injury. Resident #01 was not transferred to the hospital for assessment and treatment until approximately seven hours later, at which time, resident was treated for his/her injuries. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 14, 2015

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
Performance Improvement and Compliance 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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 30th day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Burns

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
Sep 28, 2015;	2015_360111_0014 (A1)	001301-14, 001441-14, 001522-15, 001691-15, 002174-15, 001940-15, 002157-15, 002270-15, 002312-15	Critical Incident System

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

LYNDA BROWN (111) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

HI Garry,
Your 2 orders (001 & 002) have been amended to included complaince date of Aug.15, 2015 as requested.
Thanks
Lynda Brown

Issued on this 28 day of September 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Health System Accountability and Performance Division
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Licensee/Titulaire de permis

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c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

LYNDA BROWN (111) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 3-5, 8-10, 12 & 15, 2015

Nine critical incident inspections were completed concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing Services, the Director of Care(DOC), Staff Educator, Resident Care Area Managers (RCAM), Director of Programs, Program Leads, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident's, and Behavioural Support Ontario (BSO) staff.

During the course of the inspection, the inspector also reviewed health records of current and deceased residents, reviewed the homes investigations, reviewed employee files, reviewed complaint logs, and reviewed the home's policies on complaints, prevention of abuse and neglect, and responsive behaviours.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

Skin and Wound Care

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

11 WN(s)
0 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident # 15, #16 & #17 were protected from physical and/or emotional abuse by the licensee or staff in the home.

Under O.Reg. 79/10, s.2(1) For the purposes of the definition of "abuse" in subsection 2(1) of the Act, "emotional abuse" means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour, or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a residents.

Under O.Reg. 79/10, s. 2(1) For the purposes of the definition of "abuse" in subsection 2(10 of the Act, "physical abuse" means, subject to subsection (2),(a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Related to log # 002157:

A critical incident report was received by the Director on a specified date for a staff to resident abuse/neglect that occurred towards Resident #15. The CIR indicated on the same date,the resident reported to Staff #109 the resident "had been experiencing difficulty" with Staff #108.

Review of the home's investigation indicated that 13 days before the CIR was submitted, Staff#109 had received two written complaints (from Staff #110 & #111) regarding allegations of improper care towards Resident #15 by Staff #108, Resident #15 had expressed fear of Staff #108, did not want Staff #108 to provide their care, Resident #15 "was upset and crying", and indicated this staff member "has a history of getting back at staff and residents when complaints about [Staff #108] are made". The actions taken (by Staff #109)indicated "spoke with resident" and informed the resident Staff # 109 would be monitoring Staff #108 for a 2 week period. Thirteen days later, a third written complaint (by Staff #109)was received by the DOC indicating Resident #15 "was asked how things had been going with [Staff #108]". The resident stated Staff #108 "does not speak to me" when providing personal care, the resident "feels sick" when Staff #108 "is going to be on duty for the next 3-4 days", and reported Staff

#108 continued to not provide assistance with toileting. Staff #108 was interviewed by DNS & DOC on the same day the third complaint letter was received and was to receive disciplinary action but the DNS indicated it did not occur until further allegations were received.

Interview of Staff #109 by the inspector, indicated that all "client feedback forms" (complaint letters) are forwarded to DOC and DNS. Staff #109 indicated when the first two complaint letters were received (13 days earlier), Staff #108 was not interviewed, did not document the incident on the resident's health record, did not report the complaints to the other staff (to monitor), and did not check on Resident #15 daily (to ensure no further incidents of emotional abuse occurred and the resident was toileted) until thirteen days later when the resident indicated the concerns continued and escalated.

Interview of Resident #15 indicated the resident was initially upset with Staff #108 (thirteen days earlier) because Staff #108 refused to provide the proper diet to the resident. The resident stated the staff member "made a big scene" in the dining room and left the resident tearful. Resident #15 indicated reporting concerns [to Staff #110 & #111] but expressed regret in reporting as [Staff #108] continued to be emotionally abusive as the staff member continued to provide the resident's personal care.

Interview of the DNS and DOC indicated awareness of written complaints received (13 days prior to submitting the CIR) and awareness of Staff #109 submitting a written complaint letter (regarding concerns with Staff #108 towards Resident #15). The DNS indicated Staff #108 "had previous disciplinary action" for improper care and was currently suspended pending investigation related to another allegation of staff to resident physical abuse towards another resident. The DNS indicated Staff #109 "took action" following the two written complaints and the DNS was unable to interview Staff #108 (after receiving the third complaint letter) because Staff #108 "was on vacation" at that time. The DNS indicated the disciplinary action was to occur following the return of Staff #108 from vacation, but was not completed yet as "other allegations came forward".

Review of the staffing schedule indicated Staff #108 was working on the day the first two written complaints were received, then worked 9 more shifts (which included the day the third complaint letter was received and one day after). Staff #108 did not go on vacation until 16 days after the first two complaint letters were received and 3 days after the third complaint letter was received. Staff #108 continued to work (and did not receive any disciplinary action) for an additional 6 more shifts when the staff member

was suspended from duty (pending the home's investigation).

Review of the Staff #108 employee record indicated the staff member had received two prior disciplinary actions for violating "resident's right to dignity" and "violating the policy on employee conduct and behaviour".

Therefore, the licensee failed to ensure that Resident #15 was protected from ongoing emotional abuse by Staff #108 by:
-failing to immediately investigate (when two allegations of emotional abuse were initially reported), and take immediate action of protecting Resident #15 from further emotional abuse by Staff #108, as action was not taken until two additional allegations were received (by other resident's/staff), as indicated under LTCHA, s.23(1)(a)(b) under WN #4.
-failing to follow the home's prevention of abuse and neglect policy, as Staff #109, DOC, and DNS did not interview all individuals involved (specifically Staff #108) until 13 days later, after the third complaint was received, and continued to allow Staff #108 to provide care to Resident #15 (despite an allegation of emotional abuse), as indicated under LTCHA, s.20(1) under WN #3.
-failing to immediately report an allegation of staff to resident emotional abuse, as the allegations initially made, were not reported to the Director until 13 days later(after the third allegation), as indicated under LTCHA, s.24(1) under WN#5.
-failing to immediately notify the SDM of Resident #15 of allegations of emotional abuse, as the SDM was not notified until after the third allegation was received, as indicated under O.Reg. 79/10, s. 97(1)(a) under WN #7.
-failing to immediately notify the police of allegations of staff to resident emotional abuse as the police were not contacted until after the second allegation was received regarding Resident #15 and Staff #108, as indicated under O.Reg.79/10, s.98 under WN #8. [s. 19.(1)]

2. Related to log #002270:

A critical incident report was received by the Director on a specified date for an allegation of staff to resident physical abuse incident that occurred. The CIR indicated two days before, at a specified time, Resident #16 reported had received physical abuse by Staff #108. Resident #16 complained of pain to a specified area and sustained an injury, as a result.

The home also received a written complaint from the family of Resident #16 (on the same day the incident occurred). A copy of the complaint letter alleging staff to

resident abuse was not immediately provided to the Director (until six days later).

Review of the home's investigation indicated on the day of the incident, Staff #112 entered Resident #16 room to assist Staff #108 with a transfer. Staff #112 found the resident "crying and visible upset" but could not understand "what was wrong" due to language barrier. Staff #112 did not report the incident until the home began their investigation (6 days later). Staff #113 indicated on the day of the incident, staff reported (at start of shift) Resident #16 had an injury to a specified area. Staff #108 reported to Staff #113 (later in the shift) that Resident #16 had another injury to a different specified area. Staff #113 assessed the resident at that time, but was unable to determine cause of injury (due to language barrier). Staff #113 waited until approximately 2 hours later (to get a translator to determine cause of injury) when Resident #16 reported (with a translator) that Staff #108 had injured the resident (earlier in the shift) and expressed "I don't like [Staff #108]", and "I am so upset". Staff #113 then reported the incident to Staff #114. Staff #114 then notified the DOC (who instructed Staff # 114) to notify the family, police, physician, and the Director. Staff #108 was also relieved of duty pending an investigation.

Review of Resident #16 progress notes also indicated the day before the allegation was made, staff had reported a large injury was noted to a specified area on the resident of unknown cause. No internal incident report was completed and there was no indication of an investigation to determine the cause of that injury.

Therefore, the licensee failed to ensure that Resident #16 was protected from physical abuse by Staff #108 by:
-failing to provide the resident's care according to resident's plan of care as Staff #108 failed to transfer the resident according to the plan, as indicated under LTCHA, s.6(7) under WN #2.
-failing to follow the home's abuse policy by Staff #112 failing to immediately report suspicion of staff to resident physical abuse, and the home failing to immediately investigating Resident #16 sustaining a large injury to a specified area that occurred the day before the allegation was made, as indicated under LTCHA, s. 20(1) under WN #3.
-failing to provide the Director a copy of a complaint letter received by the home from the family of Resident #16, alleging staff to resident physical abuse, as indicated under O.Reg.79/10, s.103(1) under WN #10. [s. 19. (1)]

3. Related to log #002312:

On a specified date, the home disclosed to the inspector that the home was currently investigating a third allegation of staff to resident abuse (involving Staff #108).

A critical incident report (CIR) was submitted to the Director on a specified date for a staff to resident physical abuse incident that occurred. The CIR indicated Staff #115 reported to Staff #109 (3 days before the CIR was submitted and 5 days before it was reported to Staff #109)"overhearing Resident #17 stating "please stop hurting me", then overheard Staff #108 stating to Resident #17 "I'm not hurting you" and the resident responded "you are hurting me now". Staff #115 did not provide a written statement of the incident until eight days after the incident occurred.

Review of the home's investigation indicated that the incident actually occurred 6 days before the incident was reported (when Staff #108 was putting Resident #17 to bed) and Staff # 115 overheard the conversation outside the resident's room as the door was left slightly ajar. Staff #109 asked Staff #115 to provide a written statement (when it was reported 6 days later) and also notified the DOC. Staff #115 did not provide the written statement until until 9 days after the incident occurred (and 4 days after reporting it to Staff # 109). There was no indication the SDM, police or the Director was notified, or an investigation (when Staff #109 was first notified), until 9 days later, when the written statement was received.

Review of Staff #108 work schedule indicated the staff member was working on the day the incident was witnessed and not on the day it was reported as occurring on the CIR. Staff #108 was then relieved of duty 2 days after the incident (pending investigation).

Therefore, the licensee failed to ensure that Resident #17 was protected from physical abuse by Staff #108 by:
-failing to follow the home's abuse policy, as staff member failed to immediately report a suspected incident of staff to resident physical abuse, as indicated under LTCHA, s. 20(1) under WN #3.
-failing to notify the SDM (within 12 hours of suspected staff to resident abuse towards Resident #17),as the SDM was not notified until 5 days after the initial report of neglect and emotional abuse, as indicated under O.Reg. 79/10, s.97(1) under WN #7.
-failing to immediately notify the police of a suspected staff to resident abuse, as indicated under O.Reg.79/10, s.98 under WN #8.
-failing to immediately investigate a suspected incident of staff to resident abuse, as Staff #109/DOC/DNS had "reasonable grounds" to suspect abuse on a specified date and did not investigate until 3 days later, as indicated under LTCHA, s.23(1) under

WN #4.
-failing to immediately report to the Director, a witnessed staff to resident abuse on a specified date when Staff #109 was first notified, as indicated under LTCHA, s. 24(1) under WN #5. [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 LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. Related to log #002270:

The licensee has failed to ensure the care set out in the plan of care, was provided to Resident #16, as specified in the plan, related to bed mobility and transferring.

A critical incident report (CIR) was received by the Director on a specified date for an allegation of staff to resident abuse/neglect incident that occurred. The CIR indicated that three days earlier, at a specified time, Resident #16 reported had been physically abused by Staff #108.

Review of the plan of care(in place at time of incident)for Resident #16 indicated under transferring & bed mobility indicated the resident was to be transferred safely with assistance of 2 staff and a full mechanical lift, to instruct the resident to bend knees and assist with pushing self up in bed with two staff assistance, and requires 2 staff to get from laying to sitting position.

Review of the home's investigation indicated on a specified date, Staff #112 had entered Resident #16 (to assist Staff #108) with a transfer. When Staff # 112 entered the resident's room, found the resident sitting on side of bed "crying and visible upset".Therefore, the resident had been repositioned (from lying to sitting) on the side of the bed with only the assistance of one staff member and resulting in pain. [s.6.(7)]

2. The licensee has failed to ensure when the resident was reassessed and the plan of care was reviewed, it was revised when the resident's care needs changed, or was no longer necessary, or the care was no longer effective for Resident #4, related to responsive behaviours.

Related to log #001522:

Note:There was previous non-compliance in 2014 related to Resident #4 for resident to resident sexual abuse.

A critical incident report (CIR)was received by the Director on a specified date for a suspected incident of resident to resident sexual abuse. The CIR indicated the incident occurred two days before when Resident #5 was found in Resident #4 room, sitting across from Resident #4, with Resident #4 pants unfastened. Both residents are cognitively impaired. The CIR indicated Resident #4 "has a previous history of sexually inappropriate behaviours". The CIR indicated no injuries to Resident #5. The actions taken by the home to prevent a recurrence included: BSO referral, door alarm to Resident #4 (to alert staff), and placed on every 15 minute checks.

Review of the progress notes for Resident #4 (for an eight month period) indicated:
-on a specified date and time, Resident #18 had wandered into the resident's room (to lay on the bed). The resident was on "every 15 minute checks".

-4 days later, Resident #18 entered the resident's room and the resident grabbed the co-resident(no injuries noted).
-3 days later, an unidentified resident wandered into the resident's room and was redirected. The resident "Remains on every 15 minute checks".
-the following month, indicated on "every 30 minute checks for aggressive behaviour towards other residents".
-the following month, an unidentified resident was found in the resident's room attempting to hit the resident with a shoe (no injuries noted).
-3 days later, (not two days later as indicated on the CIR) staff witnessed Resident #5 sitting in a wheelchair in Resident #4 room. Resident #4 was sitting in a chair across from the resident with pants zipper was undone. Resident #5 was removed from the room. Staff noted "unaware of exact time last seen" but was last sitting at nursing station and "Every 15 minute checks" were started for 3 days.
-6 days later, BSO indicated "no further incidents or behaviours" but "DOS and every 15 minutes checks started".
-3 days later, staff indicated "spoke to maintenance to put a door alarm on resident's door to alert staff to all who come and go from room". The "door alarm in place and care plan updated".
-8 days later, the resident was relocated to a room closer to nursing station "for closer observation".
-7 days later, the resident was observed removing the yellow wander-guard strip from door, and attempting to wander into other resident's rooms. The resident "was angry" with redirection and threw the wander-guard at staff. Extra staff were called to the unit for assistance. The resident expressed being "upset" with use of door alarm and staff turned off the door alarm. Later in the shift the resident was observed "quickly entering and exiting the room to avoid setting off the door alarm. Remains on every 15 minute checks".
-2 days later, the resident was found hiding the yellow wander-guard.
-11 days later, the BSO noted "resident remains on BSO program, on every 15 minute checks, staff to ensure door alarm and yellow wander-guard is in place".

Observation of Resident #4 (over a two day period)indicated the resident's door was closed and the door alarm was in place and activated. There was no yellow wander guard in place.

Interview of Staff #116 indicated Resident #4 is unpredictable, can be physically & verbally aggressive towards staff and other residents, and has a history of sexually inappropriate behaviour (towards staff and other residents). Staff #116 indicated the resident no longer uses the yellow wander guard as "the resident doesn't understand

what it is for and removes it". Staff #116 indicated the resident is on every 30 minutes checks and door alarm in place/activated "unless the resident deactivates it or demands the door remain open and then staff have to turn it off".

Interview of BSO staff indicated the resident frequently will remove the yellow wander-guard and hide in room but it is to remain in place. The BSO staff indicated the resident always had a door alarm (previous to incident on the CIR) but the resident kept turning it off. The BSO staff indicated a different door alarm was put in place (8 days later) which was placed higher and more difficult for the resident to deactivate.

Review of the plan of care for Resident #4(in place prior to incident on CIR) indicated the resident demonstrated the following responsive behaviours:
1) wandering: staff allow the resident to wander the unit safely, door alarm in place to notify staff (when resident is in and out of the room) and if co-resident's are entering the residents room, staff are to respond promptly, and yellow wander-guard placed at door to prevent co-residents from entering.
3)Socially inappropriate or disruptive (teases other residents, "overly friendly" with specific co-residents (touching, will take them into own room, uses sexual inappropriate words towards staff, exposes/touches own genitals in presence of specific co-residents). Interventions included: staff to re-direct resident to own room if speaking in a sexually inappropriate manner, remove other co-residents who may react or resident may act inappropriate with, initiate behaviour tracking every 15 minutes (for a previous incident of inappropriate touching of a specific resident and exposing genitals, door alarm on door frame, avoid sitting resident next to any female residents if possible, monitor resident if wandering unit and if approaches other specific residents, remove specific resident if resident not able to be redirected, referral to Ontario Shores, monitor groin area for irritation to determine possible cause of exposure of private areas, and remind resident of unacceptable behaviour.

Therefore, the interventions of a door alarm, and yellow wander-guard, that were to be used to manage the responsive behaviours of sexually inappropriate behaviour, were supposed to be already in place (prior to the incident on the CIR and despite being indicated on CIR as actions taken to prevent recurrence), and when those interventions were determined to be no longer necessary or ineffective (as the resident and/or staff would remove/deactivate), the plan of care was not revised until 8 days later (when a new door alarm was applied). The care plan indicated the yellow wander-guard that was to be used (and which the resident continuously removed and continued to remain ineffective) was also not in place over a two day period (to prevent other residents from entering the resident's room). The progress notes also

indicated "a door alarm was not in place" until eight days after the the incident occurred. [s. 6. (10)]

3. Related to log #002174:

A critical incident report was received by the Director on a specified date for a resident to resident physical abuse incident. The CIR indicated on the same day and at a specified time, Resident #7 was found on the floor in own room and had reported to staff the resident "had been kicked" by Resident #8. Resident #7 sustained a an injury requiring transfer to hospital as a result. The long term actions indicated Resident #7 "already had a door alarm in place but was only activated during the night and will now be activated 24/7". Resident #8 "had a door alarm" put in place and both residents were "to be monitored every 15 minutes and already on BSO program".

Review of progress notes for Resident #8 (for a three month period) indicated:
-on a specified date, BSO noted "not showing any aggressive behaviour for 3 weeks so every 15 minute checks discontinued".
-13 days later, the resident was found in Resident #12 room sleeping in the resident's bed. Resident #12 was found sitting in wheelchair in the room.
-4 days later, BSO noted "discontinued from the BSO program due to no documentation of resident having any behaviours".
-10 days later, staff were attempting to redirect the resident out of Resident #13 room but resident became "physically abusive".
-5 days later, Resident #7 was found in own room sitting on the floor complaining of pain and injury to a specified area, requiring transfer to hospital. The resident reported Resident #8 had "kicked the resident" and Resident #8 was found sleeping in Resident #7 bed.
-13 days later, BSO noted "resident monitoring decreased from every 15 minutes to every 30 minutes as behaviours has now decreased".

Review of the care plan for Resident #8 (in place prior to incident on CIR) indicated the following responsive behaviours/interventions:
1) wandering: allow to wander in safe supervised areas of secure unit, seek and determine resident's whereabouts to ensure is safe, determine if any reason for wandering (eg. toileting needs), in BSO program, and respond to door alarms promptly.
2) physically abusive behaviour (unpredictable-will hit out at staff and other residents). Interventions included: 1:1 staff when needed, redirect from other residents when needed, ensure door alarm is on when in room so staff alerted when the resident

leaves the room, on every 15 minute checks for responsive behaviour (but discontinued if no behaviours noted in last 3 weeks).

Observation of Resident #8 room (on a specified date) indicated a staff member entered the resident's room. The staff member deactivated the door alarm and then failed to reactivate the door alarm upon exiting the room.

Review of the plan of care for Resident #7 related to responsive behaviours of wandering also indicated the resident already had a door alarm in place (prior to incident on the CIR) and did not indicate the door alarm was only activated "during the night" as indicated on the CIR.

Therefore, the interventions of a door alarm for Resident #8, (that was to be used to manage the responsive behaviours of physical aggression and wandering)were already in place prior to the incident, (despite what was indicated on CIR as actions taken to prevent recurrence). There was no indication in the progress notes that the door alarm for Resident #8 was activated (on three separate dates) when the resident was wandering into other resident's room. The plan of care for Resident #7 also already had a door alarm that was already in place as an intervention to manage the responsive behaviour of wandering and did not indicate was to be only activated during the night (as indicated on the CIR). The other interventions to manage Resident #8 responsive behaviour(BSO monitoring) was also discontinued despite the resident demonstrating aggressive /wandering behaviours. [s. 6. (10)]

4. Related to log #001441:

A critical incident report(CIR) was received by the Director on a specified date for an allegation by Resident #3 of sexual assault. The CIR indicated the incident occurred two days before at a specified time. In the "description of the occurrence" the resident was assessed (when returned to bed) and indicated "excoriation and swelling" and a small injury was noted to the same area. The resident also reported "someone came into my room" and sexually assaulted the resident.

Interview of Staff #101 indicated Resident#3 “has a history of" displaying and vocalizing inappropriate sexual responsive behaviours.

Interview of Staff #103 stated "I have heard on report in the past that [Resident #3] has displayed and vocalized some inappropriate sexual behaviours".

Interview of BSO team member #104 indicated BSO team was not aware of Resident #3 demonstrating "inappropriate sexual responsive behaviours" until after the allegation (that was made and on CIR) and a referral to BSO was received.

Interview of RAI-Coordinator indicated the plan of care for Resident #3 was revised after the allegation of sexual abuse was made.

Review of the progress notes for Resident #3 indicated:
- on a specified date and time, the resident was calling for help and complained of soreness to a specified area. The resident was assessed and treatment was provided to the reddened area. Staff noted the resident "has habit of" rubbing the specified area "causing redness" and expresses loneliness.
-3 days later, the RPN indicated "during supper, resident complained of soreness" to a specified area. The resident was assessed later that evening (after going to bed). Staff noted excoriation, swelling to the specified area and scant amount of blood. Resident reported "someone came to the room" and sexually assaulted the resident. Resident also stated "it was dark and screamed for help and no one came". No screaming was noted throughout the shift. POA was notified and "note left for MD". Treatment cream applied.
-2 days later, BSO member indicated "resident referred to BSO r/t unusual behaviour of sexually inappropriate comments/yelling in public areas (dining room). The resident has been expressing loneliness, has been reported to be displaying inappropriate sexual responsive behaviours in public areas and asking staff to assist with these behaviours. Staff noted the behaviours have been worsening "over the last 2 weeks". Diagnostic test completed to rule out infection and placed on every 30 minute checks. Staff to report any unusual/escalated behaviour exhibited by resident and rule out any physical cause (infections, discomfort, etc.). New order received from physician to restart antidepressant (was discontinued), further diagnostic test to rule out infections, and request Nurse Practitioner (NP) to complete an exam to the specified area. The NP completed the exam and indicated the resident reported "has been rubbing" to stop the discomfort that is ongoing. Staff provided specific cleaning instructions to specified area and a new order for treatment cream. Later that evening, police arrived for investigation of incident.
-the following day, the staff documented the resident was yelling out for help and reporting someone was inappropriately touching the resident but no one had entered the resident's room and remains on every 30 minute checks.
-two days later staff documented the resident remained on behavioural tracking as still vocalizing sexually inappropriate words.

Review of the care plan (was revised post incident)for Resident #3 indicated socially inappropriate or disruptive behaviour: reported to display and vocalize sexually inappropriate behaviours in public areas which was triggered with decrease in antidepressant. Interventions included: rule out possible causes (irritation, itchiness, or discomfort/rule out infection), move resident to private room if displaying seuxally inappropriate behaviours, remind/discourage resident of inappropriate comments disrupting other residents, assess symptoms and review medications. Staff to apply barrier treatment cream as ordered, keep skin dry and clean, staff to complete daily skin assessments and report to charge nurse any problems, report to charge nurse any displaying towards self of sexually inappropriate behaviours, notify MD/NP if irritation persists (to assess), and avoid using soap to area.

There was no indication the plan of care was reviewed and revised when the resident's needs/condition changed (re: possible infection as displayed as sexually inappropriate responsive behaviours) as the resident had been exhibiting responsive behaviours (that were not documented) and displaying alteration in skin integrity (as a result of the responsive behaviours) and interventions were not implemented until after the resident expressed "someone came into my room" and sexually assaulted the resident.[s.6.(10)(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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the home's policy " Abuse Policy-staff to resident and competent resident to another resident" (RSL-RR-010) indicated:
- on page 1 of 5: "all alleged/actual/suspected cases of abuse will be recognized, reported and investigated.
Under procedure for reporting abuse (page 3 of 5) indicated:
-upon knowing of any incident or alleged, actual or suspected abuse, the witness will immediately intervene to ensure the resident's well- being.
-immediately removing the persons allegedly or suspected of the inflicting of the abuse from the immediate area and any resident home areas, pending further investigation.
-the Registered Staff will update the plan of care and progress notes following the incident, inclusive of measures to assess the resident's physical and/or psychosocial well-being post incident as well as interventions supporting the resident and to prevent recurrences.
-the Administrator, DOC or designate will discuss the incident with the implicated individuals and develop a plan of action. The plan will be documented. [s.20.(1)]

2. Related to log # 001441:

A critical incident report(CIR)was received by the Director on a specified date for an allegation by Resident #3 of sexual abuse. The CIR indicated the incident occurred 2 days before it was reported to the Director. In the "description of the occurrence" (during a specified time) the resident reported complaints of discomfort to a specified area to the RPN. The resident was assessed approximately 2 hours later, and noted "excoriation and swelling" and a small bruise to the specified area. The resident also reported at that time had been sexually assaulted.

Review of the staff schedule indicated Staff #100, Staff #101 and Staff #103 worked

on the unit with Resident #3 on the date the incident was reported.

Interview of the DNS indicated she contacted Staff #100 the day after the incident to inquire why the staff member "had not called anyone to report the allegation of sexual abuse" and the staff member indicated "had reported the incident to the DOC". The DNS also indicated "the progress notes contained all the investigation".

Interview of the DOC indicated Staff #100 did not report any allegation by Resident #3 of sexual abuse and was not aware of the allegation until the following day.

Interview of Staff #103 indicated on the day the incident occurred, (at the specified time) heard Resident #3 calling out "Help, help!". Staff #103 indicated went to see Resident #3 and the resident reported being sexually assaulted. The staff member indicated the resident was provided reassurance and then immediately reported the incident to Staff #101.

Interview of Staff #101 indicated on the date of the incident, Resident #3 was complaining of discomfort to a specified area during a meal time (but has history of discomfort to the specified area) and indicated would assess later when resident was in bed. The staff member indicated approximately 2 hours later, heard the resident calling out. The staff member indicated that was when the resident reported being sexually assaulted. The staff member indicated completed an assessment of the resident, documented the assessment and then notified Staff #100.

Interview of Staff #100 indicated on the date of the incident, Staff #101 reported Resident #3 had alleged being sexually assaulted. The staff member "assumed" it may have been a staff member but Resident #3 was not questioned to determine "who" the resident was alleging had sexually assaulted the resident (to determine whether it was a staff, resident or visitor). The staff member indicated an assessment of the resident was then completed and then directed Staff #101 to complete an incident report, contact the POA and the physician. The staff member denied notifying the DOC or DNS, or the Administrator, did not call the after-hours for the MOHLTC, or contact the police, despite an allegation by a resident of being sexually assaulted.

Review of the progress notes for Resident #3 on the day the incident was reported, Staff #101 noted "note left for" physician".

Therefore, the home's policy was not complied with as an alleged case of sexual abuse was not immediately recognized, reported and investigated by the Staff #100

until the following day, when the DNS and DOC became aware of the incident and actions were taken. [s. 20. (1)]

3. Related to log # 002157:

Interview of the DNS and DOC on June 4, 2015, indicated that although there were 2 "client feedback forms" received on a specified date (regarding allegations of staff to resident improper care and emotional abuse by Staff #108 towards Resident #15), Staff #109 "had taken action to resolve the issue" at that time. The DNS indicated an investigation was not completed (until 13 days later) when a third complaint letter was received by Staff #109 alleging staff to resident emotional abuse and improper care by Staff # 108 (when Staff #108 returned from vacation). The DNS indicated Staff #108 was to receive disciplinary action for the first 3 reported incidents, but then additional information was received (regarding two additional incidents of staff to resident abuse by Staff #108 towards two other residents). The DNS indicated approximately one month later was when action was taken with Staff #108 (suspended pending the investigation into all the allegations).

Review of the staffing schedule for Staff #108 indicated the staff member worked on the day of the first two incidents that were reported, worked 9 more shifts (including the day the third complaint was received and the day after) before the staff member went on vacation. Staff #108 then returned from vacation and continued to work and was not suspended (pending investigation) until 5 days later (when the fifth and sixth complaints were received regarding other residents).

Interview of Staff #109 indicated two "client feedback forms" were received on a specified date, regarding concerns of neglect and emotional abuse of Resident #15 by Staff #108. Staff #109 indicated Staff #108 was not interviewed on the day the client feedback forms were received but only spoke to the resident. Staff #109 indicated the concerns identified on the "client feedback forms" were not reported to the other supervisor's to follow-up, did not document the incidents reported on the resident's health record, and did re-assess Resident #15 each day to ensure no further incidents occurred (until 13 days later) when Resident #15 was interviewed again by Staff #109. Staff # 109 indicated when Resident #15 was interviewed, indicated the concerns related to Staff #108 continued and escalated.

The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with as the RN failed to immediately remove the persons allegedly or suspected of the inflicting of the abuse from the

immediate area and any resident home areas, pending further investigation. Staff # 109 failed to update the plan of care and progress notes following the reported allegations of staff to resident emotional abuse and neglect, inclusive of measures to assess the resident's physical and/or psychosocial well-being (post incident) as well as interventions supporting the resident and to prevent recurrences. The Administrator, DOC or designate also did not discuss the incident with the implicated individual (Staff #108)and develop a plan of action to prevent a reoccurrence until approximately one month later(after 3 additional allegations were received). [s. 20. (1)]

4. Related to log # 002270:

Review of the progress notes for Resident #16 indicated on a specified date, the resident was found with a large injury to a specified area. There was no indication of an investigation to determine the cause of injury on that date. The following day, Staff #112 witnessed a "suspected" staff to resident physical abuse towards Resident #16(involving Staff #108) and did not report the incident for 4 days.

Therefore, the licensee failed to comply with the home's abuse policy by failing to immediately report, intervene, and investigate a suspected case of staff to resident physical abuse. [s. 20(1)]

5. Related to log #002312:

On June 12, 2015 the home disclosed to the inspector that the home was currently investigating a third allegation of staff to resident abuse (involving Staff #108).

A critical incident report (CIR) was submitted to the Director (the same day) for a staff to resident abuse/neglect incident that occurred 8 days before the CIR was submitted (and reported to the Inspector). The CIR indicated Staff #115 reported (4 days after the incident occured) witnessing a "suspected" staff to resident physical abuse towards Resident #17 by Staff #108.". Staff #115 did not provide a "written statement" to the management regarding the incident 8 days after the incident occurred.

Review of the home's investigation indicated 5 days after the incident was witnessed (not 4 as indicated on CIR), Staff #115 reported witnessing a suspected staff to resident physical abuse (towards Resident #17 by Staff #108) to Staff #109. Staff #109 asked Staff #115 to provide a written statement and then immediately notified the DOC of the incident. Staff #115 did not provide the written statement until 4 days later, and that was when the home began the investigation.

Therefore, the licensee failed to ensure the home's abuse policy was complied with as a staff member has reasonable grounds to suspect staff to resident physical abuse and did not report the incident for 6 days and then failed to provide a written statement for an additional 3 days, there was no indication an investigation was completed (when the incident was first reported to Staff #109), and there was no indication the SDM, police or the Director was notified, until 9 days later (when the written statement was received by Staff #115). [s. 20. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Related to log # 001441:

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported is immediately investigated.

Review of the progress notes, interview of staff and review of the homes investigation indicated:
- on a specified date and time,the resident complained of discomfort to a specified area. The resident was assessed and had noted excoriation, scant amount of blood, and a small bruise noted to the area. The resident reported "someone came to the room" and sexually assaulted the resident.
-The RN did not investigate to determine who the resident was alleging.
-Interview of the DNS indicated the RN was contacted the following day to inquire why the RN "had not called anyone to report the allegation of sexual abuse" of Resident #3 and the RN indicated at that time, "had reported the incident to the DOC".
-the DOC denied receiving a call from the RN on the day the incident was reported and was not made aware of the allegation until the following day.
-The DNS had no written investigation "as the progress notes contained all the investigation". [s.23. (1)(a)]

2. Related to log # 002174:

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported is immediately investigated.

A critical incident report received by the Director on a specified date, indicated on the same day at a specified time, a resident to resident physical abuse incident had occurred. The CIR indicated Resident #8 allegedly kicked Resident #7 resulting in an injury which resulted in transfer to hospital and significant change in condition.

Interview of the DOC indicated there was no formal investigation completed into the incident "as we knew what happened and directed the staff to ensure the Ministry and Police were called and document the interventions on the progress notes". The DOC indicated the CIR would be the only other place where the investigation would be indicated.

The Director of Nursing Services stated "we only complete a formal investigation when staff are involved or the aggressive resident is cognitive" as both residents involved were cognitively impaired. [s. 23. (1) (a)]

3. Related to log # 002157:

Review of the home's investigation, interview of staff & resident, and review of the

resident's health record indicated that Staff #109 had received two written complaints on a specified date from Staff #110 & #111 regarding concerns of staff to resident emotional abuse and neglect towards Resident #15 by Staff #108. The written complaints alleged improper care and that Resident #15 was "fearful" of Staff #108 and did not want the staff member to continue to provide care. Staff #109 "spoke with resident" and told the resident that Staff #109 would be tracking concerns with Staff #108 for 2 weeks. There was no indication that this action was taken, and no indication of an investigation when the initial complaints were received. [s. 23.(1)(a)]

4. Related to log # 002312:

At the time of the inspection, the home disclosed to the inspector that the home was currently investigating further allegations of staff to resident abuse related to PSW #108. A critical incident report (CIR) was submitted to the Director the same day for a staff to resident abuse/neglect incident that occurred 8 days earlier.

Review of the home's investigation indicated that the staff member who witnessed a suspected staff to resident physical abuse failed to immediately report the suspicion for 6 days, and when the allegation was reported, there was no documented evidence of an investigation until the staff member provided a written statement (9 days later). [s. 23. (1) (a)]

WN #5: 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 abuse of a resident by anyone, that resulted in harm, immediately reported the suspicion and the information upon which it was based to the Director.

Related to log # 001441:

A critical incident report(CIR)was received by the Director on a specified date for an allegation by Resident #3 of sexual abuse. The CIR indicated the incident occurred the day before it was submitted at a specified time. Interview of the DOC confirmed the Director was notified until the following day[s.24 (1)].

2. Related to log # 001522:

A critical incident report (CIR)was received by the Director on a specified date for a suspected incident of resident to resident sexual abuse that occurred 2 days before the CIR was submitted at a specified time between Resident #4 & #5. Review of the health care record of Resident #4 & #5 indicated the incident actually occurred 2 days before the CIR was submitted.

Interview of the DOC indicated the CIR (that was submitted to the Director) was not required as both residents were "cognitively impaired". The DOC indicated after staff

were interviewed regarding the incident, they determined the the correct date of the occurrence.[s. 24. (1)]

3. Related to log # 001940:

The home had completed 3 internal "resident incident reports" on three separate dates (within a 3 week period) related to Resident #14's sustaining injuries to specified areas (of unknown cause). The Director was not notified until 5 days later, when the family member of Resident #14 submitted a written complaint regarding the injuries (of unknown cause). [s. 24. (1)]

4. Related to log # 002157:

Review of the home's investigation indicated that RN #109 had received two written complaints on a specified date from Staff #110 & #111 regarding concerns from Resident #15 towards Staff #108. The written complaints alleged improper care and that Resident #15 was "fearful" of Staff #108 and did not want the staff member to continue to provide their care.

Interview of Staff #109 indicated the Director was not notified on the day the written complaints were received (but the DNS & DOC were).
Interview of the DNS indicated Staff #109 "took action" at the time of the written complaints were received and the Director was not notified until 13 days later, when Staff #109 submitted a written complaint letter alleging staff to resident emotional abuse and neglect. [s.24(1)]

5. Related to log # 002312:

At the time of the inspection, the home disclosed to the inspector that the home was currently investigating further allegations of staff to resident abuse related to Staff #108.

A critical incident report (CIR) was submitted to the Director on the day it was reported to the Inspector for a staff to resident abuse/neglect indicating the incident which occurred 8 days earlier.

Review of the home's investigation indicated:
-the incident actually occurred 9 days before it was reported,
-Staff #112 witnessed a suspected staff to resident physical abuse by Staff #108

towards Resident #17 but did not report to Staff #109 for 5 days. Staff #109 reported the incident immediately to the DOC & DNS. The DNS indicated the investigation was not initiated when Staff # 109 reported it to DOC & DNS as they were "waiting for the written statement" by Staff #112 and the statement was not provided for 4 more days (which was when the allegation was reported to the Director). [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents; O. Reg. 79/10, s. 53 (2).
(b) based on the assessed needs of residents with responsive behaviours; and O. Reg. 79/10, s. 53 (2).
(c) co-ordinated and implemented on an interdisciplinary basis. O. Reg. 79/10, s. 53 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that for all programs and services, the matters referred to in subsection (1) are (a) integrated into the care that is provided to all residents.

Review of the home's "Responsive Behaviours" (09-05-01) (revised September 2010) indicated the matters referred to in subsection (1) are identified in this policy. However, the home utilizes a Behavioural Supports Ontario (BSO) program in the home (for the past three years) and utilizes tools which are not identified in the homes Responsive Behaviours policy.

The DNS indicated the BSO program has been in use for the past 3 years.

Interview of two BSO team members indicated an awareness that the home's new policy does not integrate the use of the BSO team that is actively used in the home to manage resident's with responsive behaviours, and tools that are actually utilized in the home (related to responsive behaviours). [s.53.(2)(a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of an alleged incident of abuse or neglect of the resident that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

Related to log #002157:

Review of the home's investigation and interview of staff indicated Staff #109 had received two written complaints on a specified date from Staff #110 & # 111. The complaint letters were regarding allegations of neglect from Resident #15 about Staff #108 and the resident was fearful of Staff #108. The allegation was not reported to the SDM until 13 days later(when Staff #109 submitted a third written complaint, reporting the same). [s.97(1)(a)]

2. Related to log #002312:

At the time of the inspection, the home disclosed to the inspector that the home was currently investigating further allegations of staff to resident abuse related to Staff # 108.

Review of the home's investigation indicated Staff #112 reported an allegation of suspected staff to resident physical abuse 6 days after the incident occurred. The allegation was not reported to the SDM until 8 days after the incident occurred (when Staff #112 submitted a written statement regarding the incident). [s. 97(1)(a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

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

Related to log # 001441:

Review of the home's investigation, interview of staff and review of Resident #3 health record indicated on a specified date and time, the resident reported "someone came to the room" and sexually assaulted the resident.

Interview of the DNS and review of the health record of Resident #3 indicated the police were notified the day after the allegation was made. [s.98]

2. Related to log # 001522:

Review of the home's investigation, review of health care records for Resident #4 & #5, and interview of staff, indicated there was a suspected incident of resident to resident sexual abuse that occurred on a specified date and time between Resident #4 & #5. Both residents were cognitively impaired and Resident #4 had a history of sexual responsive behaviours towards other residents. Review of the progress notes for Resident #4 indicated on a specified date and time, "the police were notified of the incident that occurred yesterday".[s.98]

3. Related to log # 002174:

A critical incident report (CIR) was received by the Director on a specified date for a resident to resident physical abuse incident. The CIR indicated on the same day and a specified time, Resident #7 was found on the floor their room and had reported to staff the resident had been physically assaulted by Resident #8 resulting in an injury requiring transfer to hospital and significant change in condition. The CIR indicated "called POA of [Resident #7] and does not want police called".

Interview of the DNS indicated "we usually call the family of the recipient of the aggression and if they don't want us to call the police, we don't call them". The police were not called regarding this incident. [s. 98.]

4. Related to log # 002157:

Review of the home's investigation, interview of staff, review of health care records,and interview of the resident indicated on a specified date, Staff #109 received two written complaints (from Staff #110 & #111) alleging improper care and Resident #15 fearful of Staff #108.

Interview of the DNS and DOC indicated the police were not contacted regarding the concerns with Staff #108 towards Resident #15 on the day the first two written complaints were received alleging neglect or 13 days later when a third written complaint was received from Staff # 109 alleging the staff to resident neglect and emotional abuse by Staff # 108 towards Resident #15. The DNS indicated the police were called approximately one month later, after receiving additional allegations of staff to resident abuse by Staff #108 (towards other residents). [s.98.]

5. Related to log # 002312:

At the time of the inspection, the home disclosed to the Inspector an allegation of staff to resident physical abuse that occurred 9 days earlier. The DNS indicated the police were notified 9 days later. [s. 98.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation was commenced immediately.

Related to log # 001940:

Interview of the DNS and DOC indicated a written complaint from a family member of Resident #14 was received on a specified date. There was no client feedback form completed regarding this complaint (as per the home's policy). There was confusion between all managers as to which of the home's "Complaint policy" (new or previous) was to be implemented (despite documented evidence to indicate that the previous complaint policy was still in use at the time the written complaint was received).Interview of the Administrator indicated that although the new ownership

took effect prior to the complaint being received, the new policies had not yet been implemented.

Review of the home's previous complaint policy "Complaint Handling Process-Client Feedback Log" (ADM-QUA-100) indicated:
- on page 1 of 2 under #3."it is the responsibility of the person receiving a concern/complaint to document the information on a Client Feedback Log Form, if a follow up is required. All sections on the form are to be completed promptly".
- under #4. "when all information has been taken, the person receiving the complaint will identify the recommended actions and note in the "actions taken" section of the form, along with names of who will be accountable for these actions".

Review of the home's investigation indicated:
- The written complaint was regarding Resident #14: being denied attendance to specific programs on more than one occasion,dietary concerns, the resident sustaining ongoing unexplained injuries to specified areas, and the family member witnessing a staff member providing rough-handling of the resident on a specified date (resulting in the resident screaming and sustaining an injury to a specified area).
-There was no documented evidence of a "Client Feedback form" completed for this written complaint (alleging improper care and possible physical abuse).
-the home's investigation included investigation into the activation and dietary concerns only.
-the DNS/DOC received 3 internal incident reports (on a specified date)where staff reported 2 injuries to specified areas to Resident #14 of unknown cause; the following month, another injury was sustained to a specified area to Resident #14.
-There was no documented evidence to indicate an investigation was completed into the cause of Resident#14 sustaining "ongoing" injuries to specified areas (prior to the incident that a written complaint was received for) and the 3 internal incident reports.
-the DNS indicated the "investigation" was concluded 13 days after the written complaint was received but the complainant was not contacted by the DNS 2 days later (when a message was left requesting an extension for the investigation). A final response was then provided to the complainant by the DNS (20 days after the written complaint was received) of the final outcome of the investigation and actions taken.
[s.101.(1) 1.]

2. The licensee failed to ensure that a documented record is kept in the home that includes: (a) the nature of each written complaint; (b) the date the complaint was received; (c) the type of action taken to resolved the complaint, including the date the action, time frames for actions to be taken and any follow-up action required.

Related to log # 001940:

Review of the home's investigation and interview of DNS, DOC and Administrator indicated a written complaint was received for Resident #14 on a specified date from the family member.

Interview of the Administrator indicated all complaints received are to be placed in the "complaint binder" along with "client feedback forms"(which indicates who the complaint was from, when the complaint was received and what actions were taken, and what outcome was). The Administrator indicated the complaints received are also tracked electronically by each unit on a complaint log, and based on this entry, trends are determined.

Review of the paper "complaints binder" for a three month period (during the time the complaint letter was received)had a copy of the complaint letter received (but no client feedback form). Review of the "electronic" complaint logs (based on client feed backs) for the month the complain letter was received, had no indication of a written complaint received by a family member alleged staff to resident "rough handling" and sustaining ongoing injuriesof unknown cause. [s.101.(2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the Director received a written complaint with respect to a matter that the licensee reports or reported to the Director, under section 24 of the Act, and a corresponding written report documenting the response the licensee made to the complainant.

Related to log # 001940:

A written complaint was received by the home on a specified date from a family member of Resident #14 regarding witnessed incident of rough-handling towards Resident #14 and ongoing, injuries sustained by Resident #14 of unknown cause.

Interview of the DNS indicated no written response was provided to the complainant or to the Director as the complainant was only notified via telephone (15 days later).

2.Related to log #002270:

The home received a written complaint from the family of Resident #16 on a specified date regarding an incident of staff to resident physical abuse. A copy of the complaint letter alleging staff to resident abuse was not provided to the Director (until six days later). [s.103(1)]

WN #11: 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:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the report to the Director included the following description of the incident:date and time of the incident.

Related to log # 002157:

A critical incident report (CIR)was received by the Director on a specified date,for a staff to resident abuse/neglect that occurred towards Resident #15. The CIR indicated on the same day, at a specified time, the resident reported to Staff #109 the resident had been experiencing difficulty with Staff #108.

Review of the home's investigation indicated on a specified date (13 days before the Director was notified), Staff #109 had received two written complaints from Staff #110 & #111 with allegations of neglect and emotional abuse from Resident #15 by Staff #108. This information was not provided on the CIR that was submitted to the Director. [s. 104. (1) 1.]

Issued on this 28 day of September 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LYNDA BROWN (111) - (A1)

Inspection No. / No de l'inspection : 2015_360111_0014 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 001301-14,001441-14,001522-15,001691-15,002174-15,001940-15,002157-15,002270-15, 002312-15 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Sep 28, 2015;(A1)

Licensee / Titulaire de permis : CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD : Orchard Villa
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Gary Hopkins

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To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, 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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007 s. 19 (1) to ensure all residents are protected from physical and emotional abuse..

The licensee shall ensure the plan includes:

1)The development and implementation of a monitoring process to ensure that:
a) the resident s SDM is immediately notified of every incident of alleged, suspected or witnessed incident of abuse and are notified with 12 hours upon
the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.
b) every alleged, suspected or witnessed incident of physical and emotional abuse of a resident, by a staff member, that the licensee knows of, or that is reported to the licensee, is immediately investigated and appropriate action is taken to ensure the safety of those residents involved (and any other residents who may be vulnerable), are protected from physical and emotional

abuse from staff.
c) the Director is immediately notified if there are reasonable grounds to suspect
the 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.
d)the appropriate police force is immediately notified of any alleged, suspected or
witnessed incident of physical and emotional abuse of a resident that the licensee suspects may constitute a criminal offence.
2) All staff and management to review the home's new policy relating to "Zero Tolerance of Abuse and Neglect", including actions to be taken by any person when a suspicion, allegation or witnessed, incident of abuse neglect has been reported,ensuring awareness of roles and responsibility, and ensuring staff clearly understand who will be responsible for completing the investigation and that the investigation is to be completed immediately, and appropriate actions to be taken as a result of the investigations.
3) Develop and implement a system to monitor and evaluate staff adherence to the Zero Tolerance of Abuse and Neglect Policy.
4) Develop and implement specific measures to be in place when non-adherence to the home's policy and or legislation is identified.
5) The plan should also identify who is responsible for ensuring the completion of
each and every item listed above.

The plan shall be submitted in writing and emailed to LTCH Inspector-Nursing,
Lynda Brown at lynda.brown2@ontario.ca on or before June 30, 2015. The plan
shall identify who will be responsible for each of the corrective actions listed and expected time from for completion.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that Resident # 15, #16 & #17 were protected from physical and/or emotional abuse by the licensee or staff in the home.

Under O.Reg. 79/10, s.2(1) For the purposes of the definition of "abuse" in subsection 2(1) of the Act, "emotional abuse" means, (a) any threatening, insulting,

intimidating or humiliating gestures, actions, behaviour, or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a residents.

Under O.Reg. 79/10, s. 2(1) For the purposes of the definition of "abuse" in subsection 2(10 of the Act, "physical abuse" means, subject to subsection (2),(a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Related to log # 002157:

A critical incident report was received by the Director on a specified date for a staff to resident abuse/neglect that occurred towards Resident #15. The CIR indicated on the same date,the resident reported to Staff #109 the resident "had been experiencing difficulty" with Staff #108.

Review of the home's investigation indicated that 13 days before the CIR was submitted, Staff#109 had received two written complaints (from Staff #110 & #111) regarding allegations of improper care towards Resident #15 by Staff #108, Resident #15 had expressed fear of Staff #108, did not want Staff #108 to provide their care, Resident #15 "was upset and crying", and indicated this staff member "has a history of getting back at staff and residents when complaints about [Staff #108] are made". The actions taken (by Staff #109)indicated "spoke with resident" and informed the resident Staff # 109 would be monitoring Staff #108 for a 2 week period. Thirteen days later, a third written complaint (by Staff #109)was received by the DOC indicating Resident #15 "was asked how things had been going with [Staff #108]". The resident stated Staff #108 "does not speak to me" when providing personal care, the resident "feels sick" when Staff #108 "is going to be on duty for the next 3-4 days", and reported Staff #108 continued to not provide assistance with toileting. Staff #108 was interviewed by DNS & DOC on the same day the third complaint letter was received and was to receive disciplinary action but the DNS indicated it did not occur until further allegations were received.

Interview of Staff #109 by the inspector, indicated that all "client feedback forms" (complaint letters) are forwarded to DOC and DNS. Staff #109 indicated when the first two complaint letters were received (13 days earlier), Staff #108 was not interviewed, did not document the incident on the resident's health record, did not report the complaints to the other staff (to monitor), and did not check on Resident

#15 daily (to ensure no further incidents of emotional abuse occurred and the resident was toileted) until thirteen days later when the resident indicated the concerns continued and escalated.

Interview of Resident #15 indicated the resident was initially upset with Staff #108 (thirteen days earlier) because Staff #108 refused to provide the proper diet to the resident. The resident stated the staff member "made a big scene" in the dining room and left the resident tearful. Resident #15 indicated reporting concerns [to Staff #110 & #111] but expressed regret in reporting as [Staff #108] continued to be emotionally abusive as the staff member continued to provide the resident's personal care.

Interview of the DNS and DOC indicated awareness of written complaints received (13 days prior to submitting the CIR) and awareness of Staff #109 submitting a written complaint letter (regarding concerns with Staff #108 towards Resident #15). The DNS indicated Staff #108 "had previous disciplinary action" for improper care and was currently suspended pending investigation related to another allegation of staff to resident physical abuse towards another resident. The DNS indicated Staff #109 "took action" following the two written complaints and the DNS was unable to interview Staff #108 (after receiving the third complaint letter) because Staff #108 "was on vacation" at that time. The DNS indicated the disciplinary action was to occur following the return of Staff #108 from vacation, but was not completed yet as "other allegations came forward".

Review of the staffing schedule indicated Staff #108 was working on the day the first two written complaints were received, then worked 9 more shifts (which included the day the third complaint letter was received and one day after). Staff #108 did not go on vacation until 16 days after the first two complaint letters were received and 3 days after the third complaint letter was received. Staff #108 continued to work (and did not receive any disciplinary action) for an additional 6 more shifts when the staff member was suspended from duty (pending the home's investigation).

Review of the Staff #108 employee record indicated the staff member had received two prior disciplinary actions for violating "resident's right to dignity" and "violating the policy on employee conduct and behaviour".

Therefore, the licensee failed to ensure that Resident #15 was protected from ongoing emotional abuse by Staff #108 by:
-failing to immediately investigate (when two allegations of emotional abuse were

initially reported), and take immediate action of protecting Resident #15 from further emotional abuse by Staff #108, as action was not taken until two additional allegations were received (by other resident's/staff), as indicated under LTCHA, s.23(1)(a)(b) under WN #4.
-failing to follow the home's prevention of abuse and neglect policy, as Staff #109, DOC, and DNS did not interview all individuals involved (specifically Staff #108) until 13 days later, after the third complaint was received, and continued to allow Staff #108 to provide care to Resident #15 (despite an allegation of emotional abuse), as indicated under LTCHA, s.20(1) under WN #3.
-failing to immediately report an allegation of staff to resident emotional abuse, as the allegations initially made, were not reported to the Director until 13 days later(after the third allegation), as indicated under LTCHA, s.24(1) under WN#5.
-failing to immediately notify the SDM of Resident #15 of allegations of emotional abuse, as the SDM was not notified until after the third allegation was received, as indicated under O.Reg. 79/10, s. 97(1)(a) under WN #7.
-failing to immediately notify the police of allegations of staff to resident emotional abuse as the police were not contacted until after the second allegation was received regarding Resident #15 and Staff #108, as indicated under O.Reg.79/10, s.98 under WN #8. [s. 19.(1)]

2. Related to log #002270:

A critical incident report was received by the Director on a specified date for an allegation of staff to resident physical abuse incident that occurred. The CIR indicated two days before, at a specified time, Resident #16 reported had received physical abuse by Staff #108. Resident #16 complained of pain to a specified area and sustained an injury, as a result.

The home also received a written complaint from the family of Resident #16 (on the same day the incident occurred). A copy of the complaint letter alleging staff to resident abuse was not immediately provided to the Director (until six days later).

Review of the home's investigation indicated on the day of the incident, Staff #112 entered Resident #16 room to assist Staff #108 with a transfer. Staff #112 found the resident "crying and visible upset" but could not understand "what was wrong" due to language barrier. Staff #112 did not report the incident until the home began their investigation (6 days later). Staff #113 indicated on the day of the incident, staff reported (at start of shift) Resident #16 had an injury to a specified area. Staff #108

reported to Staff #113 (later in the shift) that Resident #16 had another injury to a different specified area. Staff #113 assessed the resident at that time, but was unable to determine cause of injury (due to language barrier). Staff #113 waited until approximately 2 hours later (to get a translator to determine cause of injury) when Resident #16 reported (with a translator) that Staff #108 had injured the resident (earlier in the shift) and expressed "I don't like [Staff #108]", and "I am so upset". Staff #113 then reported the incident to Staff #114. Staff #114 then notified the DOC (who instructed Staff # 114) to notify the family, police, physician, and the Director. Staff #108 was also relieved of duty pending an investigation.

Review of Resident #16 progress notes also indicated the day before the allegation was made, staff had reported a large injury was noted to a specified area on the resident of unknown cause. No internal incident report was completed and there was no indication of an investigation to determine the cause of that injury.

Therefore, the licensee failed to ensure that Resident #16 was protected from physical abuse by Staff #108 by:
-failing to provide the resident's care according to resident's plan of care as Staff #108 failed to transfer the resident according to the plan, as indicated under LTCHA, s.6(7) under WN #2.
-failing to follow the home's abuse policy by Staff #112 failing to immediately report suspicion of staff to resident physical abuse, and the home failing to immediately investigating Resident #16 sustaining a large injury to a specified area that occurred the day before the allegation was made, as indicated under LTCHA, s. 20(1) under WN #3.
-failing to provide the Director a copy of a complaint letter received by the home from the family of Resident #16, alleging staff to resident physical abuse, as indicated under O.Reg.79/10, s.103(1) under WN #10. [s. 19. (1)]

3. Related to log #002312:

On a specified date, the home disclosed to the inspector that the home was currently investigating a third allegation of staff to resident abuse (involving Staff #108).

A critical incident report (CIR) was submitted to the Director on a specified date for a staff to resident physical abuse incident that occurred. The CIR indicated Staff #115 reported to Staff #109 (3 days before the CIR was submitted and 5 days before it was reported to Staff #109)"overhearing Resident #17 stating "please stop hurting

me", then overheard Staff #108 stating to Resident #17 "I'm not hurting you" and the resident responded "you are hurting me now". Staff #115 did not provide a written statement of the incident until eight days after the incident occurred.

Review of the home's investigation indicated that the incident actually occurred 6 days before the incident was reported (when Staff #108 was putting Resident #17 to bed) and Staff # 115 overheard the conversation outside the resident's room as the door was left slightly ajar. Staff #109 asked Staff #115 to provide a written statement (when it was reported 6 days later) and also notified the DOC. Staff #115 did not provide the written statement until until 9 days after the incident occurred (and 4 days after reporting it to Staff # 109). There was no indication the SDM, police or the Director was notified, or an investigation (when Staff #109 was first notified), until 9 days later, when the written statement was received.

Review of Staff #108 work schedule indicated the staff member was working on the day the incident was witnessed and not on the day it was reported as occurring on the CIR. Staff #108 was then relieved of duty 2 days after the incident (pending investigation).

Therefore, the licensee failed to ensure that Resident #17 was protected from physical abuse by Staff #108 by:
-failing to follow the home's abuse policy, as staff member failed to immediately report a suspected incident of staff to resident physical abuse, as indicated under LTCHA, s. 20(1) under WN #3.
-failing to notify the SDM (within 12 hours of suspected staff to resident abuse towards Resident #17),as the SDM was not notified until 5 days after the initial report of neglect and emotional abuse, as indicated under O.Reg. 79/10, s.97(1) under WN #7.
-failing to immediately notify the police of a suspected staff to resident abuse, as indicated under O.Reg.79/10, s.98 under WN #8.
-failing to immediately investigate a suspected incident of staff to resident abuse, as Staff #109/DOC/DNS had "reasonable grounds" to suspect abuse on a specified date and did not investigate until 3 days later, as indicated under LTCHA, s.23(1) under WN #4.
-failing to immediately report to the Director, a witnessed staff to resident abuse on a specified date when Staff #109 was first notified, as indicated under LTCHA, s. 24(1) under WN #5. [s. 19. (1)] (111)

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

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

Aug 15, 2015(A1)

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, s. 6 - Plan of Care, specific to, s. 6 (10)(b)(c).

The homes plan shall include:
1) Review and revise the plan of care for Resident #3, #4, #7 & #8 s plan of care (and any other residents demonstrating sexually and physically aggressive responsive behaviours towards other residents), to ensure the plan of care and interventions to manage these responsive behaviours, are implemented, and that the plan of care is reviewed and revised, when no longer necessary or determined to be ineffective is provided to the resident, as indicated in the plan.
2) to ensure there is a process in place to monitor that the resident s are reassessed
and the plan of care is reviewed and revised at least every six months, and at
any other time, when the resident's care needs change; to ensure the plan of care is reflective of resident care needs, related to the identified residents (and any other resident s demonstrating physically aggressive and sexually inappropriate responsive behaviours), towards other residents.

The plan shall be submitted in writing and emailed to LTC Homes Inspector, Lynda Brown at lynda.brown2@ontario.ca on or before June 30, 2015. The plan shall identify who will be responsible for each of the corrective action listed.

Grounds / Motifs :

1. 1. Related to log #002270:

The licensee has failed to ensure the care set out in the plan of care, was provided to Resident #16, as specified in the plan, related to bed mobility and transferring.

A critical incident report (CIR) was received by the Director on a specified date for an allegation of staff to resident abuse/neglect incident that occurred. The CIR indicated that three days earlier, at a specified time, Resident #16 reported had been physically abused by Staff #108.

Review of the plan of care(in place at time of incident)for Resident #16 indicated under transferring & bed mobility indicated the resident was to be transferred safely with assistance of 2 staff and a full mechanical lift, to instruct the resident to bend knees and assist with pushing self up in bed with two staff assistance, and requires 2 staff to get from laying to sitting position.

Review of the home's investigation indicated on a specified date, Staff #112 had entered Resident #16 (to assist Staff #108) with a transfer. When Staff # 112 entered the resident's room, found the resident sitting on side of bed "crying and visible upset".Therefore, the resident had been repositioned (from lying to sitting) on the side of the bed with only the assistance of one staff member and resulting in pain. [s.6.(7)]

2. The licensee has failed to ensure when the resident was reassessed and the plan of care was reviewed, it was revised when the resident's care needs changed, or was no longer necessary, or the care was no longer effective for Resident #4, related to responsive behaviours.

Related to log #001522:

Note:There was previous non-compliance in 2014 related to Resident #4 for resident to resident sexual abuse.

A critical incident report (CIR)was received by the Director on a specified date for a suspected incident of resident to resident sexual abuse. The CIR indicated the incident occurred two days before when Resident #5 was found in Resident #4 room, sitting across from Resident #4, with Resident #4 pants unfastened. Both residents are cognitively impaired. The CIR indicated Resident #4 "has a previous history of sexually inappropriate behaviours". The CIR indicated no injuries to Resident #5. The actions taken by the home to prevent a recurrence included: BSO referral, door alarm to Resident #4 (to alert staff), and placed on every 15 minute checks.

Review of the progress notes for Resident #4 (for an eight month period) indicated:
-on a specified date and time, Resident #18 had wandered into the resident's room (to lay on the bed). The resident was on "every 15 minute checks".
-4 days later, Resident #18 entered the resident's room and the resident grabbed the co-resident(no injuries noted).
-3 days later, an unidentified resident wandered into the resident's room and was

redirected. The resident "Remains on every 15 minute checks".
-the following month, indicated on "every 30 minute checks for aggressive behaviour towards other residents".
-the following month, an unidentified resident was found in the resident's room attempting to hit the resident with a shoe (no injuries noted).
-3 days later, (not two days later as indicated on the CIR) staff witnessed Resident #5 sitting in a wheelchair in Resident #4 room. Resident #4 was sitting in a chair across from the resident with pants zipper was undone. Resident #5 was removed from the room. Staff noted "unaware of exact time last seen" but was last sitting at nursing station and "Every 15 minute checks" were started for 3 days.
-6 days later, BSO indicated "no further incidents or behaviours" but "DOS and every 15 minutes checks started".
-3 days later, staff indicated "spoke to maintenance to put a door alarm on resident's door to alert staff to all who come and go from room". The "door alarm in place and care plan updated".
-8 days later, the resident was relocated to a room closer to nursing station "for closer observation".
-7 days later, the resident was observed removing the yellow wander-guard strip from door, and attempting to wander into other resident's rooms. The resident "was angry" with redirection and threw the wander-guard at staff. Extra staff were called to the unit for assistance. The resident expressed being "upset" with use of door alarm and staff turned off the door alarm. Later in the shift the resident was observed "quickly entering and exiting the room to avoid setting off the door alarm. Remains on every 15 minute checks".
-2 days later, the resident was found hiding the yellow wander-guard.
-11 days later, the BSO noted "resident remains on BSO program, on every 15 minute checks, staff to ensure door alarm and yellow wander-guard is in place".

Observation of Resident #4 (over a two day period)indicated the resident's door was closed and the door alarm was in place and activated. There was no yellow wander guard in place.

Interview of Staff #116 indicated Resident #4 is unpredictable, can be physically & verbally aggressive towards staff and other residents, and has a history of sexually inappropriate behaviour (towards staff and other residents). Staff #116 indicated the resident no longer uses the yellow wander guard as "the resident doesn't understand what it is for and removes it". Staff #116 indicated the resident is on every 30 minutes checks and door alarm in place/activated "unless the resident deactivates it

or demands the door remain open and then staff have to turn it off".

Interview of BSO staff indicated the resident frequently will remove the yellow wander-guard and hide in room but it is to remain in place. The BSO staff indicated the resident always had a door alarm (previous to incident on the CIR) but the resident kept turning it off. The BSO staff indicated a different door alarm was put in place (8 days later) which was placed higher and more difficult for the resident to deactivate.

Review of the plan of care for Resident #4(in place prior to incident on CIR) indicated the resident demonstrated the following responsive behaviours:
1) wandering: staff allow the resident to wander the unit safely, door alarm in place to notify staff (when resident is in and out of the room) and if co-resident's are entering the residents room, staff are to respond promptly, and yellow wander-guard placed at door to prevent co-residents from entering.
3)Socially inappropriate or disruptive (teases other residents, "overly friendly" with specific co-residents (touching, will take them into own room, uses sexual inappropriate words towards staff, exposes/touches own genitals in presence of specific co-residents). Interventions included: staff to re-direct resident to own room if speaking in a sexually inappropriate manner, remove other co-residents who may react or resident may act inappropriate with, initiate behaviour tracking every 15 minutes (for a previous incident of inappropriate touching of a specific resident and exposing genitals, door alarm on door frame, avoid sitting resident next to any female residents if possible, monitor resident if wandering unit and if approaches other specific residents, remove specific resident if resident not able to be redirected, referral to Ontario Shores, monitor groin area for irritation to determine possible cause of exposure of private areas, and remind resident of unacceptable behaviour.

Therefore, the interventions of a door alarm, and yellow wander-guard, that were to be used to manage the responsive behaviours of sexually inappropriate behaviour, were supposed to be already in place (prior to the incident on the CIR and despite being indicated on CIR as actions taken to prevent recurrence), and when those interventions were determined to be no longer necessary or ineffective (as the resident and/or staff would remove/deactivate), the plan of care was not revised until 8 days later (when a new door alarm was applied). The care plan indicated the yellow wander-guard that was to be used (and which the resident continuously removed and continued to remain ineffective) was also not in place over a two day period (to prevent other residents from entering the resident's room). The progress

notes also indicated "a door alarm was not in place" until eight days after the the incident occurred. [s. 6. (10)]

3. Related to log #002174:

A critical incident report was received by the Director on a specified date for a resident to resident physical abuse incident. The CIR indicated on the same day and at a specified time, Resident #7 was found on the floor in own room and had reported to staff the resident "had been kicked" by Resident #8. Resident #7 sustained a an injury requiring transfer to hospital as a result. The long term actions indicated Resident #7 "already had a door alarm in place but was only activated during the night and will now be activated 24/7". Resident #8 "had a door alarm" put in place and both residents were "to be monitored every 15 minutes and already on BSO program".

Review of progress notes for Resident #8 (for a three month period) indicated:
-on a specified date, BSO noted "not showing any aggressive behaviour for 3 weeks so every 15 minute checks discontinued".
-13 days later, the resident was found in Resident #12 room sleeping in the resident's bed. Resident #12 was found sitting in wheelchair in the room.
-4 days later, BSO noted "discontinued from the BSO program due to no documentation of resident having any behaviours".
-10 days later, staff were attempting to redirect the resident out of Resident #13 room but resident became "physically abusive".
-5 days later, Resident #7 was found in own room sitting on the floor complaining of pain and injury to a specified area, requiring transfer to hospital. The resident reported Resident #8 had "kicked the resident" and Resident #8 was found sleeping in Resident #7 bed.
-13 days later, BSO noted "resident monitoring decreased from every 15 minutes to every 30 minutes as behaviours has now decreased".

Review of the care plan for Resident #8 (in place prior to incident on CIR) indicated the following responsive behaviours/interventions:
1) wandering: allow to wander in safe supervised areas of secure unit, seek and determine resident's whereabouts to ensure is safe, determine if any reason for wandering (eg. toileting needs), in BSO program, and respond to door alarms promptly.
2) physically abusive behaviour (unpredictable-will hit out at staff and other

residents). Interventions included: 1:1 staff when needed, redirect from other residents when needed, ensure door alarm is on when in room so staff alerted when the resident leaves the room, on every 15 minute checks for responsive behaviour (but discontinued if no behaviours noted in last 3 weeks).

Observation of Resident #8 room (on a specified date) indicated a staff member entered the resident's room. The staff member deactivated the door alarm and then failed to reactivate the door alarm upon exiting the room.

Review of the plan of care for Resident #7 related to responsive behaviours of wandering also indicated the resident already had a door alarm in place (prior to incident on the CIR) and did not indicate the door alarm was only activated "during the night" as indicated on the CIR.

Therefore, the interventions of a door alarm for Resident #8, (that was to be used to manage the responsive behaviours of physical aggression and wandering)were already in place prior to the incident, (despite what was indicated on CIR as actions taken to prevent recurrence). There was no indication in the progress notes that the door alarm for Resident #8 was activated (on three separate dates) when the resident was wandering into other resident's room. The plan of care for Resident #7 also already had a door alarm that was already in place as an intervention to manage the responsive behaviour of wandering and did not indicate was to be only activated during the night (as indicated on the CIR). The other interventions to manage Resident #8 responsive behaviour(BSO monitoring) was also discontinued despite the resident demonstrating aggressive /wandering behaviours. [s. 6. (10)]

4. Related to log #001441:

A critical incident report(CIR) was received by the Director on a specified date for an allegation by Resident #3 of sexual assault. The CIR indicated the incident occurred two days before at a specified time. In the "description of the occurrence" the resident was assessed (when returned to bed) and indicated "excoriation and swelling" and a small injury was noted to the same area. The resident also reported "someone came into my room" and sexually assaulted the resident.

Interview of Staff #101 indicated Resident#3 “has a history of" displaying and vocalizing inappropriate sexual responsive behaviours.

Interview of Staff #103 stated "I have heard on report in the past that [Resident #3] has displayed and vocalized some inappropriate sexual behaviours".

Interview of BSO team member #104 indicated BSO team was not aware of Resident #3 demonstrating “inappropriate sexual responsive behaviours” until after the allegation (that was made and on CIR) and a referral to BSO was received.

Interview of RAI-Coordinator indicated the plan of care for Resident #3 was revised after the allegation of sexual abuse was made.

Review of the progress notes for Resident #3 indicated:
- on a specified date and time, the resident was calling for help and complained of soreness to a specified area. The resident was assessed and treatment was provided to the reddened area. Staff noted the resident "has habit of" rubbing the specified area "causing redness" and expresses loneliness.
-3 days later, the RPN indicated “during supper, resident complained of soreness” to a specified area. The resident was assessed later that evening (after going to bed). Staff noted excoriation, swelling to the specified area and scant amount of blood. Resident reported "someone came to the room" and sexually assaulted the resident. Resident also stated "it was dark and screamed for help and no one came". No screaming was noted throughout the shift. POA was notified and "note left for MD". Treatment cream applied.
-2 days later, BSO member indicated “resident referred to BSO r/t unusual behaviour of sexually inappropriate comments/yelling in public areas (dining room). The resident has been expressing loneliness, has been reported to be displaying inappropriate sexual responsive behaviours in public areas and asking staff to assist with these behaviours. Staff noted the behaviours have been worsening "over the last 2 weeks”. Diagnostic test completed to rule out infection and placed on every 30 minute checks. Staff to report any unusual/escalated behaviour exhibited by resident and rule out any physical cause (infections, discomfort, etc.). New order received from physician to restart antidepressant (was discontinued), further diagnostic test to rule out infections, and request Nurse Practitioner (NP) to complete an exam to the specified area. The NP completed the exam and indicated the resident reported "has been rubbing" to stop the discomfort that is ongoing. Staff provided specific cleaning instructions to specified area and a new order for treatment cream. Later that evening, police arrived for investigation of incident.
-the following day, the staff documented the resident was yelling out for help and reporting someone was inappropriately touching the resident but no one had entered

the resident's room and remains on every 30 minute checks.
-two days later staff documented the resident remained on behavioural tracking as still vocalizing sexually inappropriate words.

Review of the care plan (was revised post incident)for Resident #3 indicated socially inappropriate or disruptive behaviour: reported to display and vocalize sexually inappropriate behaviours in public areas which was triggered with decrease in antidepressant. Interventions included: rule out possible causes (irritation, itchiness, or discomfort/rule out infection), move resident to private room if displaying sexually inappropriate behaviours, remind/discourage resident of inappropriate comments disrupting other residents, assess symptoms and review medications. Staff to apply barrier treatment cream as ordered, keep skin dry and clean, staff to complete daily skin assessments and report to charge nurse any problems, report to charge nurse any displaying towards self of sexually inappropriate behaviours, notify MD/NP if irritation persists (to assess), and avoid using soap to area.

There was no indication the plan of care was reviewed and revised when the resident's needs/condition changed (re: possible infection as displayed as sexually inappropriate responsive behaviours) as the resident had been exhibiting responsive behaviours (that were not documented) and displaying alteration in skin integrity (as a result of the responsive behaviours) and interventions were not implemented until after the resident expressed "someone came into my room" and sexually assaulted the resident.[s.6.(10)(b)] (111)

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

Aug 15, 2015(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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 28 day of September 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Ottawa

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 4, 2016	2016_280541_0003	001043-16	Complaint

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

AMBER MOASE (541)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): On-site February 22 and off-site March 4, 2016.

This inspection was for complaint log #001043-16, a complaint related to dietary services.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Food Service Manager, the Food Service Supervisor and Dietary Aides.

The following Inspection Protocols were used during this inspection:
Dining Observation

During the course of this inspection, Non-Compliances were not issued.

- **0 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

Issued on this 4th day of March, 2016

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

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 sions 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
Apr 19, 2016;	2015_365194_0028 (A1)	031205-15	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

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

CHANTAL LAFRENIERE (194) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

The compliance date for CO #05 has been extended to July 31, 2016 at the licensee's request to accommodate completion of identified repairs.

Issued on this 19 day of April 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 19, 2016;	2015_365194_0028 (A1)	031205-15	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

CHANTAL LAFRENIERE (194) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

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

This inspection was conducted on the following date(s): November 16, 17, 18, 19, 20,23,24,25,26 and 27, 2015

Inspected during the Resident Quality Inspection are the following Logs: Log #007731-14, #006626-15, #028395-15, #032651-15, #002102-15, #009024-15, #010570-15, #018385-15, #032511-15, #007008-15, #011818-15, #004080-15, #004459-15, #004545-15, #004833-15, #005280-15, #027862-15, #032865-15, #032857-15, #007018-15, #015635-15, #016142-15, #019935-15, #020272-15, #028832-15, #015525-15, #019428-15, #023370-15, #025473-15, #033207-15.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Residents, Families, Director of Quality (DOQ), Registered Nurse (RN), Resident Care Area Manager (RCAM), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Environmental Manager, Nurse Administrative Assistant, Dietary Manager, Dietitian, Occupational Therapist (OT), Housekeeping, Dietary Aide,

Also completed in the inspection: Tour of the building, observation of dining services, medication administration practices, infection control practices and staff to resident provision of care. Reviewed clinical health records of identified residents, relevant policies, licensee's internal investigations, staff educational records, relevant program evaluations, maintenance records, complaint log, Resident and Family Council minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Admission and Discharge

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Trust Accounts

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

19 WN(s)
5 VPC(s)
5 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. 6. (10)	CO #002	2015_360111_0014	552

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. A Compliance Order (CO #001), under LTCHA, 2007, s. 19, was issued during inspection #2015_360111_0014, which included a written notification (WN) specific to LTCHA, 2007, s. 24 (1); with a compliance date of August 15, 2015

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident, has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

For the purpose of the definition of "abuse in subsection 2(1) of the Act, "financial abuse", means any misappropriation or misuse of a resident's money or property.

During an interview with resident #020 on November 17, 2015, the resident brought forward concerns that a total of $270.00 went missing from his/her wallet about three weeks prior, and that this was reported to the Administrator. Resident #003 also brought forward concerns that $40.00 went missing during the night and this was reported. A review of the home's complaint log could not locate any documented record in relation to the above concern for resident #020, but there was documented record for resident #003's missing funds. A review of the home's record could not locate a report submitted to the Director in relation to the above identified missing funds. An interview with the Administrator confirms that he did not complete or submit a report regarding the above identified concerns to the Director.(607)

Related to Intake #032511-15, for Resident #058:

The licensee failed to comply with LTCHA, 2007, s. 24. (1), by not ensuring a person who has reasonable grounds to suspect that abuse of a resident has occurred or may

occur shall immediately report the suspicion and the information upon which it is based to the Director, specifically as it relates to:

For the purpose of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means, the use of physical force by anyone other than a resident that causes physical injury or pain.

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident of physical abuse, which the home categorized as being "improper/incompetent treatment of a resident that results in harm or risk to a resident".

The Critical Incident Report indicated that on an identified date, two Personal Support Workers were transferring Resident #058, using a mechanical ceiling lift from wheelchair to bed, during the transfer Resident #058's medical equipment became entangled around the mechanical ceiling lift's arm bar, pulling on the medical equipment, which resulted injury to Resident #058; resident was transferred to hospital for assessment and treatment.

Director of Care indicated to the inspector the incident and subsequent injury to Resident #058 resulted from Personal Support Workers #162 and #163 not following the home's Safe Lifts and Transfers policy and practice.

Director of Care (DOC) indicated to the inspector that she was informed, by the Resident Care Area Manager, of the incident. DOC indicated that the Director was not immediately informed of the physical abuse, as she was directed by the Administrator to wait until the next day to speak with the home's Consultant (Extendicare Assist). Director of Care indicated, she is aware that the CIR was late being reported to the Director.

The Director was not informed of the physical abuse that resulted in harm to the resident until two days later.(554) [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. Related to Intake #011818-15, for Resident #62:

The licensee failed to comply with LTCHA, 2007, s. 6 (2), by not ensuring the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Resident #062 is cognitively well and ambulatory with use of a mobility aid. Resident #062 had a known falls risk.

The Director of Care submitted a Critical Incident Report to the Director, an identified date, specific to an incident that caused an injury to a resident for which the resident was taken to hospital which resulted in a significant change in a resident's health status.

Progress notes reviewed for Resident #062, during a fourteen day period detail the following:
- On an identified date Resident #062 was on the toilet, stood and the resident's legs

gave out; two Personal Support Workers (PSWs) lowered the resident to the floor, and was later assisted off the floor and into bed using a mechanical lift and four staff. Resident #062 was assessed by a Registered Nurse (RN) and found to have no injuries
- twenty five minutes later, Resident #062 complained of limb pain; RN reported that there was no swelling noted to resident's limb; an analgesic was administered for complaints of pain.
- two hours later, Resident #062 was found on the floor beside the bed. Resident was assisted off the floor by aide of three staff and a mechanical lift. Resident #62 complained of the same limb pain and indicated to Registered Practical Nurse (RPN) #177 that the pain was 10/10 (severe pain); RPN's assessment noted resident's limb was swollen and resident had increased pain with range of motion (ROM).
–An hour and half later, RPN administered 'as needed' (PRN, narcotic medication).
- Two hours and forty minutes later, Resident #062 was still complaining of pain; swelling of the limb was noted to persist. RPN elevated resident's limb in bed and applied an ice pack. RPN placed a note in the physician's book, indicating need for assessment.
- Three and a half hours later, Resident #062 continued to complain of pain and the limb continued to swell; resident requested pain medication. Resident #062 was told by Registered Practical Nurse #177 that the PRN (narcotic pain medication) was only ordered as a 'once a day medication' and medication could not be administered Resident #062 was told by RPN #177 that her next scheduled pain medication was not to be given for another hour and a half.
-Registered Nurse on day shift reported in the progress note that Resident #062 was complaining of severe pain (10/10) to the limb; resident's limb remained swollen. RPN administered routine pain medication.
- Half an hour later, Resident #062 was also complaining of being nauseated and was administered an antiemetic.
- Resident #062 was assessed by physician, new orders for ice pack to resident's limb twice daily.
- The following day, Resident #062 continued to complain of pain to the limb; progress notes indicated limb remained swollen; resident refused to go to bathroom, due to 'hurting' and was incontinent. RN indicated in the progress note that resident refused to get out of bed.
- The evening shift documented that, Resident #062 was found unresponsive; ambulance was called and resident was transferred to hospital for assessment; resident was admitted to hospital.

Registered Practical Nurse #177, who was the Charge Nurse when Resident #062

fell, indicated to the inspector that the physician was not notified, as to resident's fall and subsequent injury which resulted in pain and swelling; when the narcotic pain medications administered were ineffective, and resident continued to complain of pain, nor when there was no further PRN pain medication available to be administered. Registered Practical Nurse #177 indicated to the inspector that the physician had not been contacted during the night as the physician was expected to visit in the morning, and RPN felt the assessment of Resident #062 could wait till then.

Resident #062 remained in hospital, for a period of twelve days, discharge with multiple medical diagnoses.

Director of Care indicated to the inspector that noting Resident #062 fell and sustained a limb injury, complained of pain despite pain medications and that PRN pain medications could not be further administered due to directions for administration, Registered Practical Nurse #177 should have contacted the physician for further direction or transferred Resident #062 to hospital for assessment of additional needs.

The licensee failed to ensure that the care set out in the plan for Resident #062 was based on an assessment of the resident's needs. When the resident's was not provided with an opportunity to be assessed by the physician for further pain management interventions and potential other significant care needs related to infection and or fractures over a twenty one hour period.

Related to Intake #032511-15, for Resident #058:

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident, which the home indicated as being 'improper/incompetent treatment of a resident that results in harm or risk to a resident'.

Details of the Critical Incident Report are as follows:
- Personal Support Worker (PSW) #162 and #163 were transferring Resident #058 from wheelchair to bed, using a mechanical ceiling lift (and sling). PSW's transferred Resident #058 into bed, attached the resident's medical equipment the left side of the bed, while one staff attempted to remove the sling from under Resident #058, the second PSW, using the hand held control, returned the mechanical (ceiling) lift to its resting position; while the mechanical ceiling lift was returning to its resting position, PSW #162 and #163 heard Resident #058 cry out; PSW's observed that Resident #058's medical equipment had been entangled on the mechanical (ceiling) lift's arm,

PSW stopped the lift, observing resident was in discomfort and bleeding.

Registered Nursing Staff assessed Resident #058 following the incident; resident continued to experience bleeding and pain. Registered Practical Nurse (RPN) #113 and Registered Nurse (RN) #152 attempted to provide nursing interventions, but attempts were unsuccessful. Registered Practical Nurse #113 reported to the Registered Nursing-Supervisor #153 that attempts to provide nursing interventions were unsuccessful, RPN #113 and RN #152 were instructed by RN-Supervisor #153 to wait fifteen minutes and to attempt again.

Registered Nurse #152 and Registered Nurse-Supervisor #153 indicated (to the inspector) that Resident #058 was experiencing discomfort and bleeding following the transferring incident, both registered nursing staff indicated that Resident #058 continued to experience bleeding and discomfort when registered nursing staff were attempting to provide nursing intervention. Both registered nursing staff (#152 and #153) indicated that the doctor was not contacted for direction as Resident #058 advanced directives were noted as a Level 2, indicating resident was to be cared for in the home.

As per the progress notes, an hour and a half later, Resident #058 was observed to have a change in condition with vital signs decreasing; resident was transferred to hospital for assessment.

The hospital discharge summary indicated, Resident #058 was assessed and referred to a specialist while at the hospital. Resident #058 was transferred back to the long-care home later that day.

The Critical Incident Report indicates Resident #058 returned to the home and was found deceased four hours later.

Director of Care indicated (to the inspector) that Registered Nursing Staff should have contacted Resident #058's attending physician (or transferred resident to hospital), for further assessment due to the transfer incident, subsequent injury and when resident continued to experience bleeding and or staff's inability to provide nursing interventions.

The licensee failed to ensure that the care set out in the plan for Resident #058 was based on an assessment of the resident's needs. When the resident was not provided with an opportunity to be assessed by the physician or transferred to the

hospital for assessment related pain management, bleeding and the inability of Registered staff to provide the nursing interventions for a period of one hour and fifteen minutes.

A Compliance Order (CO #001), under LTCHA, 2007, s. 6(2) was issued during inspection #2015_293554_ 0009, specific to the care set out in the plan of care being based on an assessment of the resident's needs and preferences. The incident involving Resident #062 was prior to the compliance due date of August 14, 2015 , but the incident involving Resident #058 was after the compliance date therefore the Order will be issued for a second time.(554) [s. 6. (2)]

2. Related to Log #006626-15 for Resident #050:

The licensee has failed to ensure that the plan of care is reviewed and revised when care set out in the plan has not been effective.

The Plan of care for Resident #050 directs a fluid balance of 900-1200 mls per day as a goal for the resident.
The food and fluid intake record for Resident #050 over the period of five days was reviewed and indicate being below the identified goal range for the resident.
The Dietitian has indicated during an interview with the inspector that if a resident is below their Fluid goal range for a 1-3 day period, nursing measures would be initiated to address the condition. After 3 days a referral would be completed for the Dietitian.
The RPN #143 indicated that nights review the fluid balance records for identified residents and "flag" the day staff for follow up. RPN # 143 indicates that Resident #050 was flagged as being below the targeted fluid goal range. RPN #143 indicates that as a nursing measure "pushing fluids" would have been initiated. RPN #143 indicated that verbal direction would have been given to the PSW staff to push fluids for the resident. RPN #143 was asked how the "pushed fluids" were monitored , RPN #143 replied that the PSW staff would report at the end of shift and documentation of the intake would be in the progress notes. I reviewed the progress notes with RPN #143 for the review period and there is no documentation related to pushing of fluids. I asked RPN # 143 if any other interventions or nursing measures had been implemented for Resident #050's poor intake status and RPN #143 replied that no there was not.

Resident #050 was admitted to the hospital following the five day review period for medical interventions.

A Compliance Order (CO #002), under LTCHA, 2007, s. 6 10(c) was issued during inspection #2015_360111_0014, specific to plans of care being revised when the care set out in the plan has not been effective. Compliance with 6(10) has been established during this inspection so no further action is required at this time. The incident (described above) involving Resident #050 was prior to the compliance due date of September 28, 2015. [s. 6. (10) (c)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Related to Intake #032511-15, for Resident #058:

The licensee failed to comply with O. Reg. 79/10, s. 36, by not ensuring staff use safe transferring and positioning devices or techniques when assisting the resident.

The home's policy, Mechanical Lifts (#01-03) directs that prior to all transfers the arm rests and footplates are to be removed from the receiving surface (e.g. wheelchair); staff are to complete a Pre-Transfer Review, which includes resident readiness, staff readiness, environment readiness and equipment readiness, if any deficiencies are identified or suspected staff are not to proceed with the transfer and to notify the supervisor.

The home's policy (Mechanical Lifts) directs that prior to a transfer (using a mechanical lift) both staff members are to complete the 6 Point Checklist (#01-12)

which is attached to the lift (which includes, is resident able to participate in the lift, is the sling applied correctly, is the sling attached to the lift correctly, is the lift path clear and are both staff members ready and positioned correctly to complete the lift. The policy (Mechanical Lift) directs that once the 6 Point Checklist is completed the resident is to be lifted two-three inches above the departing surface (e.g. wheelchair) and staff are to once again check that the sling is positioned properly, resident is comfortable, resident is balanced under the lift mechanism, and if any deficiencies are identified resident is to be lowered, sling re-applied and 6 Point Checklist is to be completed again. The policy (Mechanical Lift) directs that the resident is to be protected from touching any part of the mechanical lift or other equipment. The home's policy (Mechanical Lift) further directs that once the resident is lowered onto the receiving surface (e.g. bed) staff are to ensure resident is comfortable and positioned correctly, then to unhook sling and return ceiling lift to the charge (docking station).

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident, which the home indicated as being 'improper/incompetent treatment of a resident that results in harm or risk to a resident'.

Details of the Critical Incident Report are as follows:
- Personal Support Worker (PSW) #162 and #163 were transferring Resident #058 from wheelchair to bed, using a mechanical ceiling lift (and sling). PSW's transferred Resident #058 into bed, attached the medical equipment onto the left side of the bed, while one staff attempted to remove the sling from under Resident #058, the second PSW, using the hand held control, returned the mechanical (ceiling) lift to its resting position; while the mechanical ceiling lift was returning to its resting position, PSW #162 and #163 heard Resident #058 cry out; PSW's observed that Resident #058's medical equipment had been entangled on the mechanical (ceiling) lift's arm, PSW stopped the lift, observing resident was in discomfort and bleeding.

Personal Support Worker #163 indicated (to the inspector) that along with PSW #162 they were transferring Resident #058 from the wheelchair into bed; PSW #163 indicated that they had attempted to place the transferring sling under Resident #058 while the resident was in the wheelchair but that the placement of the sling was difficult due to Resident #058 refusing to allow the wheelchair arms to be removed and that the space between the bed and wheelchair was small, making placement of the sling difficult. PSW #163 indicated that they had asked Resident #058 to hold onto the transfer sling handles and other medical equipment while they (PSW #162 and

#163) proceeded to transfer resident from chair to bed. PSW #163 indicated that once resident was in the sling, PSW #163 moved to the opposite side of the bed and pushed the start button (ceiling lift control); PSW #163 indicated that while the ceiling lift was still in motion (resident was over the bed), PSW #163 attempted to remove resident's shoes while still operating the lift, and it was during this time that Resident #058 began to scream. PSW #163 indicated that the medical equipment was caught on the sling handles and handles of the ceiling lift and was accidentally pulled when transferring the resident from wheelchair to bed.

Personal Support Worker #163 indicated (to the inspector) that PSW #163 and PSW #162 should have followed the home's safe transfer and lifting procedures while transferring Resident #58; PSW #163 indicated that they (PSWs) did not removed the wheelchair arm rests prior to the transfer making it difficult to place the sling under the resident and making it difficult to clearly visualize the transfer pathway; PSW #163 further indicated that Resident #058 should have been safely positioned in bed prior to removing the shoes or sling and that they (PSWs) should have been more aware of where resident's medical equipment placement prior to and during the transfer (with ceiling lift). PSW #163 indicated that PSW #163 and PSW #162 did not complete the 6 Point Checklist prior to transferring Resident #058.

The Director of Care indicated (to the inspector) that "Personal Support Workers #162 and #163 were not following the home's Safe Lifting with Care Program", specifically the Mechanical Lifts Policy (#01-03) "which contributed the incident and subsequent injury of Resident #058".

DOC indicated that PSW's #162 and #163 did not follow the home's Safe Lifting with Care Program, by not doing the following:
- remove the arm rest of Resident #058's wheelchair; indicating it is the home's policy and practice that the arm rest of the wheelchair is to be removed with all transfers involving the use of a mechanical lift, as it creates a 'blind spot' and that potentially items could become entangled around the arm of wheelchair;
- complete that six-point checklist prior to and during use of a mechanical lift, specifically PSW #162 and #163 did not ensure the mechanical lift path was clear; during the incident, Resident #058's medical equipment became entangled in the handle of the lift, and when returning the lift to its charge (docking station).
- and that following the transfer of Resident #058 from wheelchair to bed, PSW's #162 and #163 did not ensure resident was properly positioned before returning the ceiling lift to the charge (docking station).

Director of Care indicated (to the inspector) that it is the expectation that all staff, who have been trained to use the mechanical lifts are to follow the home's Safe Lifting with Care Program.

Related to Intake #015525-15, for Resident #010:

A Critical incident report indicated that on an identified date. PSW stated that when the staff pulled the Geri chair forward, resident #010 suffered an injury.

Review of the plan for Resident #010 in effect at time of incident indicated the resident has multiple diagnoses including Cognitive Impairment, is totally dependent in transferring, and fragile skin.
The plan of care related to transferring, skin integrity and comfort directs to staff to:
-Put pillows on both sides of the resident's elbows when sitting in the wheelchair/lounge chair to prevent injury.
-Assess resident's ability to transfer safely prior to each transfer.
-Protect pressure areas with pillows and heel poseys.
Resident #010's progress notes were reviewed. On an identified date RPN #188 documented that, PSW reported an injury was sustained to Resident #010. Possible cause: as per staff, when pulled up the Geri chair, resident was injured.
Interview with PSW #186 indicated that PSW #186 and PSW #187 were preparing the resident to be transferred from Geri chair to bed; PSWs removed the pillows from both side of the resident. PSW #186 indicated to inspector #570 during an interview that when the staff moved the back of the chair forward from reclining to a sitting position the back of the chair snapped back; then realized that the resident's limb was caught between back of chair and arm rest. PSW #187 should have protected the resident's limb at the time; PSW #187 indicated the chair is an old style and was not orientated on how to use it and realized after the incident the need to push the foot rest of the chair backwards for the back of the chair to lock in position.

Review of investigation notes and statement by PSW #187 indicated the staff removed the right pillow first, as the staff turned around the resident's limb was down on the side of the chair. When moving the resident limb gently blood was noticed and RPN was called. PSW #186 was on the other side of the chair. RPN #188 indicated before pulling the Geri chair forward, PSWs #186 and 187 removed the pillows and they had been instructed that they pull the pillows out last.

Review of the investigation notes and plan of care for resident #010 indicated the PSW staff did not ensure the resident's safety when removing supporting/protective

pillows while preparing the resident to transfer from chair to bed.(570) [s. 36.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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

Findings/Faits saillants :

1. Related to Intake #0028395, for Resident #029:

The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

On an identified date Resident #029 was given another resident's medication in error by RPN #134. Resident #029 had a fall and was found by RPN #135 who was carrying medications for another resident when the RPN walked by Resident #029's room and found the resident on the floor. RPN #135 entered the room to ensure resident was safe, and RPN #134 also entered the room and was instructed by RPN #135 to watch the medication cup which was placed out of the resident's reach, while RPN called for help. When RPN #135 returned to the room, RPN #134 had given the medications to resident #029.

Subsequently Resident # 029 experienced a significant drop in blood pressure. [s. 131. (1)]

2. Related to Intake #007008-15, for Resident #046:

The licensee failed to comply with O. Reg. 79/10, s. 131 (2), by not ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A review of the clinical health record, for Resident #046, for the period of ten days, indicates that resident had been deemed palliative; according to progress notes, physician's orders and interviews with a Resident Care Area Manager and the Director of Care, Resident #046 was having difficulties with pain control.

On an identified date, Resident #046's attending Physician prescribed a STAT pain medication to be given subcutaneously; then routinely, subcutaneously every two hours for comfort.

According to a Critical Incident Report, Resident #046 was not administered any of the scheduled doses of pain medication, during an eight hour shift, despite a physician's order for medication to be given every two hours.

Director of Care indicated (to the inspector) that the medication incident was investigated and it was found that Registered Practical Nurse #114 who was the assigned charge nurse, did not only not administer the prescribed pain medication to Resident #046 during the identified shift, but also missed a scheduled dose of pain medication, for Resident #046, the following day.

According to the Director of Care, Registered Practical Nurse (RPN) #114 indicated Resident #046 was asleep and since resident was sleeping, the RPN felt that the medication was not required.

Director of Care indicated that Registered Practical Nurse #114 should have awakened Resident #046 to administer the pain medication especially noting resident had been experiencing pain control and management difficulties, and indicating the physician ordered the medication to be given every two hours.

2) Related to Resident #043:

According to the physician's orders, Resident #043 was prescribed pain medication every eight hours, for pain control.

A medication incident report, as well as the medication administration record and narcotic administration record, for Resident #043, provides documented evidence that Registered Practical Nurse #114 failed to administer the prescribed dose of pain medication to Resident #043 on an identified date.

Registered Practical Nurse #114 indicated to the Director of Care, that she had forgotten to administer the pain medication to Resident #043.

Director of Care indicated (to the inspector) the expectation is that physician's orders are to be followed as directed. [s. 131. (2)

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with 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 failed to comply with LTCHA, 2007, s. 15 (2) (a), by not ensuring that the home, furnishings and equipment are kept clean and sanitary.

The following observations were made, during the dates of November 16, to November 20, and November 23 to the 24, 2015:
- Toilets – dark blackish-brown staining was observed surrounding base of toilet (stool) and the surrounding flooring in multiple resident washrooms and in the Birch/Maple, Pine and Linden tub/shower rooms;
- Floors – multiple resident rooms were observed to have dark brownish-black build up (query grout or dirt) along flooring seams, flooring thresholds (transition piece from hall to resident room, or resident room to washroom) and along wall/flooring edges (especially in corners), as well as in the activity room adjacent to Pine, Pine and Linden lounges, resident home area hallways (Maple, Pine, Birch and Linden), as well as the Linden and Pine tub/shower rooms. The brownish-black build up could be scraped off when scraped with a pen, by the inspector;
- Floors – visible dust and debris, especially in corners of rooms were observed in the activity room and kitchenette adjacent to Pine (resident home area), in the Pine lounge, in the Linden and Pine tub/shower rooms and in the Atrium (basement);
- Vents – observed to have thick grey film to ceiling vent in the Linden tub/shower room; observed to have blackish film on and around the ceiling vent in the Birch lounge;
- Windows / Door – cob-webs were observed lining the inside of the window and doorway of the activity room adjacent to Pine (resident home area); as well as the window located at end of the Birch (resident home area) corridor;
- Commode – observed to have brownish staining smeared along edges of commode seating and on commode rails in two resident washrooms.
- Privacy Curtain – was observed stained along the width of the curtain panel in a resident room.

Environmental Services Manager (ESM) indicated awareness of floors in the home being soiled and in need of cleaning, especially in common areas of the home, and indicated (to the inspector) that Housekeeping Staff had not been following the 'deep cleaning policies and practices' and such has resulted in cleanliness issues throughout the home. ESM indicated (to the inspector) that a new roll-out schedule, for deep cleaning, is being introduced to housekeeping staff week of November 26, 2015.

Environmental Services Manager indicated the expectation is that the home, furnishings and equipment are kept clean and sanitary. [s. 15. (2) (a)]

2. Related to Intake #009024-15 and #010570-15:

The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

An anonymous complainant contacted the Ministry of Health and Long-Term Care's Action Line indicating that windows in the Pine resident home area and in the Pine tub/shower room were broken and in need of repair. The anonymous complainant indicated that cloths were being shoved into the window opening to prevent cold air from coming into resident rooms and or tub/shower room. The anonymous caller indicated reporting this concern to the management of the home without resolution.

Window latches (opening mechanism) on windows located in the Pine tub/shower and in the activity room (adjacent to Pine) were observed broken and unable to be closed during the dates of November 16, and again November 20, 2015.

Environmental Services Manager indicated (to the inspector) that he was not made aware of the window latches being broken, until he noticed it himself on November 20, 2015; ESM indicated (to the inspector) he relies on staff (nursing and housekeepers) to alert him of deficiencies and areas in need of repair via the PM Works (electronic maintenance requisitions).

2) The home's policy, Preventative Maintenance – Maintenance Program Overview (#MNTC-01-01-01) direct that the maintenance program will maintain the building (and equipment) in a condition that provides a safe, comfortable and pleasant environment for the residents.

The following observations were made during the dates of November 16, through to November 20, 2015:
- Walls: were observed scraped, gouged, paint chipped or having wall damage (dry wall exposed, holes or corner steel beading exposed) in multiple resident rooms or washrooms; in lounges located on Pine, Linden, Birch, Aspen and Cedar; in tub/shower rooms located on Birch/Maple, Pine, Linden, Asphen and Cedar; along hallways in Pine, Asphen, and Cedar;in the main dining room; and on the wall under the severy in the Cedar dining area was 'rippled' in appearance (query water damage);
- Tiled Walls: the ceramic tiled walls in tub/spa rooms located on Linden, Asphen and

Cedar were observed cracked, chipped or having missing wall tiles; areas were wall tiles were chipped and or missing were noted to have jagged edges which were sharp; the lower edges of the wall tiles (along shower stall) and laminate flooring in the Linden, Cedar and Asphen tub/shower rooms were noted to have a blackish, moist substance along the length of the shower stall (this concern was reported to the Environmental Services Manager by the inspector, as such poses a potential infection control issue);
- Doors and Door Frames: were observed to be chipped, paint missing, holes or having jagged metal edges on doors or door frames in resident rooms/washrooms and in the lounges located on Birch, Linden and Pine;
- Closets: were observed scraped (blackish marks) and or being off the track in resident rooms.
- Wall Guard – observed loose or missing in multiple resident rooms.
- Curtains: observed to be thread-bear (worn) or having the rubber backing of the curtain cracked or torn in resident rooms;
- Counter-top Vanities: were observed chipped (exposed porous surface) or missing laminate missing in multiple resident washrooms; in the main dining room on and around the hand-sink vanity and along the severy counter;
- Chairs: home owned chairs were observed to be chipped, worn (shellac finish missing) and having blackish staining on the chair legs in resident rooms;
- Sink Vanity: the metal legs attached to the counter-top vanities in resident washrooms were observed stained (blackish) or having areas of corrosion or rust, in washrooms located in resident rooms;
- Commodes and or Shower Chairs: were observed with rusted areas or corrosion in a resident washroom and in the tub/shower room on Linden;
- Toileting Safety Rails: rust was observed on the toileting hand rails in washrooms;
- Bedside Tables: were observed to be chipped (porous surface exposed) or missing laminate surround, in resident rooms;
- Bed-rails: were observed to have paint chipped along the railing in resident rooms;
- Transfer Pole: was observed rusted, this transfer pole was located in the Pine tub/shower room;
- Baseboard Heater (rad): was observed to have the radiator cover missing in a resident room;
- Foot board (beds): observed to have the laminate lifting along the foot board edges in a resident room;
- Towel-bar: observed to be missing in resident washrooms; in all three rooms the steeling casing in place to hold the towel bar was still present and noted to have sharp edges;
- Flooring: laminate flooring was observed gouged, chipped, cracked, torn, having

holes and or lifting in areas, in multiple resident rooms or washrooms; in tub/shower rooms located on Linden, Pine, Asphen and Cedar; in the hallways on Maple and Birch; foyer entry (flooring threshold) leading from Birch into Cedar; and in the activity room (adjacent to Pine); uneven flooring poses a trip fall hazard;
- Flooring: ceramic tiled floor was observed chipped and cracked in the main foyer of the home; the brick (stone) flooring was chipped in areas of the atrium (solarium) near the stairs; and the cement threshold leading from the atrium (solarium) into the games room was observed uneven;
- Flooring – laminate flooring in the Asphen tub/shower room was observed to be lifting in areas around the floor drain, this same area was 'soggy' feeling when the inspector stepped on it and water gushed out of the flooring from around the metal floor drain; the metal floor drain was covered with a black, moist substance; this room was noted to have a stale smelling odour (this was reported to Environmental Services Manager by the inspector, as such poses a potential infection control issue);
- Metal Blinds – observed bent (several horizontal sections) in the Pine lounge;
- Window Screen: in activity room (adjacent to Pine) was observed torn, the frame of the screen was bent and hanging from window;
- Light – one light in the Birch lounge was out (not working) during the dates of November 16-19; this room was dimly lit during the dates identified.

Housekeeping Aides, Personal Support Workers and Registered Nursing Staff all indicated (to the inspector) that staff are to utilize PM Works to communicate maintenance repairs required within the home when observed; nursing staff interviewed indicated that they normally only use PM Works for equipment repairs or equipment, and or furnishings that are broken; nursing staff indicated (to the inspector) that they do not use PM Works to address wall and or flooring problems to maintenance, as they felt maintenance were aware of repairs (maintenance) needed within the building.

Environmental Services Manager indicated (to the inspector):
- being aware that there were maintenance deficiencies within the home, but indicated that he was not aware of many of the above identified repairs, as such had not been communicated to him or the maintenance department by nursing and or housekeeping staff via the PM Works (electronic maintenance requisitions); Environmental Services Manager indicated (to the inspector) that the day to day maintenance of the home (e.g. wall repairs, painting) was behind by approximately six weeks, as the maintenance workers were pulled from their daily job-schedules to work on another project in the home, therefore putting maintenance repairs behind;
- being aware of flooring replacement for three resident washrooms located in Pine

(resident home area), but he was not aware of any other flooring being replaced or repaired as of the time of this inspection.

Environmental Services Manager indicated it is an expectation that the home, furnishings and equipment are to be maintained in a safe condition and in a good state of repair, but such was difficult with the home being an older building.

Note:
The areas identified above, are random observations by inspectors and do not include all of the maintenance repairs or replacement required within the home [s. 15. (2) (c)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 005

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Related to Intake #032511-15, for Resident #058:

The licensee failed to comply with O. Reg. 79/10, s. 8 (1) (b), by not ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specifically as it relates to continence care.

Under O. Reg. 79/10, s. 48 (1) 3, every licensee of a long-term care home shall ensure the following interdisciplinary programs are developed and implemented in the home, which includes, a continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.

The home's policy, Removal of Indwelling Catheter (#RESI-05-04-12) directs registered nursing staff will remove a catheter when a physician's order has been received; registered nursing staff will insert syringe into the catheter valve leading to the balloon, withdraw empty syringe and repeat action until tubing leading from the valve collapses ensuring balloon is empty. The policy (in bold lettering) notes that registered nursing staff are never to cut the valve tubing to release the solution, as there is no way of emptying the balloon once the valve is gone.

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident, which the home indicated as being 'improper/incompetent treatment of a resident that results in harm or risk to a resident'.

Details of the Critical Incident Report are as follows:
- Personal Support Worker (PSW) #162 and #163 were transferring Resident #058 from wheelchair to bed, using a mechanical ceiling lift (and sling) on an identified date. PSW's transferred Resident #058 into bed, attached the medical equipment onto the left side of the bed, while one staff attempted to remove the sling from under Resident #058, the second PSW, using the hand held control, returned the mechanical (ceiling) lift to its resting position; while the mechanical ceiling lift was returning to its resting position, PSW #162 and #163 heard Resident #058 cry out; PSW's observed that Resident #058's medical equipment had been entangled on the mechanical (ceiling) lift's arm, PSW stopped the lift, observing resident was in discomfort and at this time noted bleeding.

Registered Nursing Staff assessed Resident #058 following the incident; resident continued to experience bleeding and pain. Registered Nursing Staff attempted to provide nursing interventions, but were unsuccessful. Registered Practical Nurse #113 and Registered Nurse #152 reported to the Registered Nursing-Supervisor that

attempts to provide nursing interventions were unsuccessful, registered nursing staff were instructed by RN-Supervisor(#153) to wait fifteen minutes and to attempt again.

Registered Practical Nurse (RPN) #113 indicated (to the inspector) that RPN #113 and RN #152 were unsuccessful in providing nursing intervention, despite several attempts. RPN #113 indicated that RN #152 proceeded with actions contrary to licensee policy. RPN #113 indicated Resident #058 was complaining of pain during attempts to provide nursing interventions.

Registered Nurse #152 indicated (to the inspector) that she was unable to provide nursing intervention. RN #152 then proceeded with actions contrary to licensee policy. RN #152 indicated resident was experiencing discomfort during attempts to provide nursing intervention.

Registered Nurse – Supervisor (#153) indicated (to the inspector) that she was aware that RN #152 proceeded with action contrary to licensee policy and indicated telling RN #152 that was not the right thing to do. RN-Supervisor indicated that the doctor was not called.

Registered Nursing Staff (#113, #152 and #153) all indicated (to the inspector) that action taken by RN # 152 was not the practice or policy of the home.

Director of Care (DOC) indicated that the RN #152 should not have proceeded with action contrary to licensee policy; DOC further indicated that the registered nursing staff should have contacted the physician when nursing interventions were unsuccessful and resident continued to voice discomfort.

Resident #058 was transferred to hospital, approximately two hours later, was seen by emergency room physician and referred to a specialist. [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 by ensuring that the licensee's policies related to continence care are complied with., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 16, by not ensuring that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

During the initial tour of the home, on November 16, 2015, the following observations were made:
- a window in the Linden (resident home area) lounge was observed open and not having a screen in place; this window could be opened fifty-eight centimetres. The Linden lounge is located on the main floor (but is a second storey lounge) of the home.
- two other windows in the Linden lounge were observed open and not having screens in place.
- a window in Pine (resident home area) lounge was observed open and not having a screen in place.

The Administrator and the Environmental Services Manager indicated (to the inspector) no awareness of the window, in Linden lounge, opening greater than fifteen centimetres; both indicated that maintenance workers had recently removed air-conditioning units and must have forgotten to replace latching (locking) mechanisms in the window in the lounge.

Environmental Services Manager indicated (to the inspector) that the home was 'short' window screens and an order had to be placed for the replacement of window screens.

2) On November 17, 2015, a window in a resident was observed to open sixty centimetres; this room is located on the main floor (but is a two storey drop) of the home.

The Administrator indicated that the resident residing in this room frequently by-passes the locking mechanism on the window, allowing the window to open greater than fifteen centimetres. Administrator indicated that there is currently no strategy or corrective action in place to monitor that the window is secured and not able to open greater than fifteen centimetres. [s. 16.]

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 by ensuring that all windows in the home that opens to the outdoors and is accessible to residents have a screen and cannot be opened more that 15 centimeters, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 17 (1) (e), by not ensuring the resident-staff communication and response system is available in every area accessible by residents.

The library, which is located in the basement of the home, was observed by the inspector to not have a resident-staff communication and response system available for resident use.

Environmental Services Manager (ESM) indicated to the inspector that the library is a resident accessible area and is used daily by a few residents; ESM indicated no awareness that the room did not have a resident-staff communication and response system.

Administrator, who oversees the operations of the home, indicated he too was not aware that the library did not have a resident-staff communication and response system in place. [s. 17. (1) (e)]

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 by ensuring that a resident-staff communication and response system is available in every area accessible by residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. Related to Intake #018385-15, for Resident #047:

The licensee failed to comply with O. Reg. 79/10, s. 101 (2), by ensuring that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and, (f) any response made by the complainant.

The home's policy, Complaints (#09-04-06) speaks to verbal complaints that cannot be resolved within twenty-four hours do not require a written investigation report; however if the verbal complaint cannot be resolved within twenty-four hours a written record of the complaint as well as the investigation and outcome will be retained.

When a verbal complaint is received, the following will occur:
- the person receiving the complaint will obtain as many details as possible regarding the complaint;
- where possible, an investigation will be initiated immediately;
- if the verbal complaint can be resolved within twenty-four hours, the person receiving the complaint or the department manager will verbally respond to the person making the complaint the outcome/resolution;
- if the investigation cannot be initiated immediately and/or resolution cannot be obtained within twenty-four hours, then the Administrator, Department Manager or

designate will initiate an investigation into the complaint, taking notes of the investigation and at the end of the investigation, review the findings and complete a written response to the complainant.
- if the investigation is not completed within six days of receiving the complaint, the Administrator will contact the complainant, acknowledging receipt of the complaint and indicate the investigation is on-going and that the investigation will be shared as soon as possible. Once the investigation is completed, the complaint will be entered into the Complaint Log Binder.

Resident #047 contacted the Long-Term Care's Action Line on an identified date, regarding the home's Administrator not allowing the resident to have a fridge in the room. Resident #047 indicated, in the concern, other residents in the home were permitted to have fridges in their rooms; Resident #47 indicated being told by the Administrator that there was a 'grand-father rule in effect which permitted any more residents from having personal fridges in their rooms'.

Centralized Intake Assessment Triage Team (C.I. A.T.T) contacted Resident #047 to discuss the concern; the same day C.I.A.T.T contacted the home's Administrator as to Resident #047's concern; Administrator indicated to C.I.A.T.T that he would follow up with Resident #047.

Resident #047 indicated (to the inspector) that prior to the call to the Ministry of Health and Long-Term Care being told that (the resident) was not able to have a small fridge in the room due to the home's policy. Resident #047 indicated (to the inspector) that there was no discussion, only a "NO" response. Resident #047 indicated receiving a call from a Ministry of Health and Long-Term Care representative, regarding the complaint and was told that the Administrator of the home would be contacting the resident; Resident #047 indicated never hearing back from the Administrator, although he did in passing one day say to the resident "I'm coming to speak to your about the fridge".

Resident #047 did indicate (to the inspector) being permitted to have a small fridge in the room, following a call to the local Member of Parliament.

Administrator indicated (to the inspector) that the complaint from Resident #047 regarding the fridge was seen as a verbal complaint;
A review of the home's Family and Resident Complaint binder, for 2015, failed to provide documented evidence of Resident #047's verbal complaint (date, nature, action taken and or response provided to the complainant).

Administrator indicated awareness of Resident #047's concern/complaint specific to the fridge, but was unable to locate any documented record of the complaint and or follow up with Resident #047. Administrator indicated that the verbal complaint from Resident #047 which was brought to his attention should have been documented as per the home's Complaints policy; Administrator indicated being unaware of when Resident #047's complaint had been resolved but indicated at some point after he had spoken with MOHLTC.

2) Related to Intake #009024-15 and #010570-15:

Anonymous complainants contacted the Ministry of Health and Long-Term Care Action Line, on an identified date, the complainant voiced concern that the home's temperature was inconsistent; the home was either too hot or too cold. The anonymous complainants indicated to MOHLTC Action Line that the complaint regarding the temperatures in the home had been brought forward to the management team on several occasions.

A review of the home's Family and Resident Complaint binder was reviewed, but failed to provide documented records of any complaints or concerns specific to temperatures within the home.

The Administrator, Director of Care and Environmental Services Manager all indicated being aware of concerns or complaints, specific to the home being too warm, but indicated that Client Feedback Forms had not been completed for any temperature (home air temperature) as "the home was doing its best to control the temperature, but due to the age of the home and the heating system in place, it was difficult to control temperatures within the home"; all indicated "there was nothing more that could be done".

Administrator indicated (to the inspector) that it is the expectation that the home's "Complaints" policy is to be followed; indicating that for the above complaints a Client Feedback Form should have been completed and filed in the Family and Resident Complaint binder

During an interview with resident #020 on November 17, 2015, the resident brought forward concerns that a total of $270.00 went missing from his/her wallet about three weeks prior, and that this was reported to the Administrator. Resident #003 also brought forward concerns that $40.00 went missing during the night and this was

reported. A review of the home's complaint log could not locate any documented record in relation to the above concern for resident #020, but there was documented record for resident #003's missing funds. A review of the home's record could not locate a report submitted to the Director in relation to the above identified missing funds. An interview with the Administrator confirms that he did not complete or submit a report regarding the above identified concerns to the Director.(607) [s. 101. (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 by ensuring a response is provided to a person who made a written or verbal complaint to the licensee or a staff member concerning the care of a resident or operation of the home, to be implemented voluntarily.

WN #10: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

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):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Related to Intake #032511-15, for Resident #058:

The licensee failed to comply with O. Reg. 79/10, s. 107 (1) 2, by not ensuring the Director was immediately informed, in as much detail as is possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide.

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident, which the home indicated as being improper/incompetent treatment of a resident that results in harm or risk to a resident. Resident #058 was transferred to the hospital later that day for assessment and treatment; Resident #058 returned to the long-term care home approximately nine hours later.

Resident was found in bed, four hours later, with vital signs absent; as per the family's request, the coroner was contacted to review the death of Resident #058.

According to the Institutional Death Record, completed and signed by the Registered Nurse-Supervisor (who was in charge of the home), Resident #058’s death was considered ‘sudden and unexpected’. Registered Nurse-Supervisor indicated (to the inspector) that she was not aware that a sudden or unexpected death was immediately reportable to the Director.

Director of Care (DOC) indicated (to the inspector) that the death of Resident #058 was unexpected; at the time of the on-site inspection the cause of Resident #058's death was considered undetermined. Director of Care indicated being unaware that a sudden and unexpected death required an immediate notification, to the Director.

The Director was not immediately informed of the sudden and unexpected death of Resident #058, until fifteen hours later. [s. 107. (1) 2.]

2. Related to Intake #011818-15, for Resident #62:

The licensee failed to comply with O. Reg. 79/10, s. 107 (3) 4, by not ensuring the Director, was informed, no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident’s health condition and for which the resident is taken to a hospital.

According to the clinical health record (written plan of care, progress notes, MDS) Resident #062 is cognitively well and required limited assistance from staff with activities of daily living; the resident was ambulatory with a walking aid, able to toilet self needing assistance with hygiene and required only supervision with transfers.

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in a resident's health status.

Resident #062 fell on an identified date; resident was assessed by Registered Nurse and found to have no injuries. twenty five minutes later resident was complaining of pain; an analgesic was administered for pain complaints.

Resident #062 fell again three hours later, resident was found on the floor in front of the bed; resident complained of pain, rating pain as severe (10/10); Registered Practical Nurse #177 noted limb be swollen and area continued to swell throughout the shift; resident was given narcotic pain medications during the shift without effect.

Progress notes, reviewed for the following two days, indicated Resident #062 continued to complain of pain and was administered routine and 'as needed' narcotic pain medications. Progress notes, indicated Resident #062 refused to go to the bathroom due to pain, therefore resident was incontinent; resident refused to get out of bed the same day.

Two days after initial fall, Resident #062 was found in bed unresponsive; ambulance was called and resident was transferred to hospital.

Registered Nursing Staff were advised by the hospital that Resident #062 was being admitted to the hospital.

Resident #062 remained in hospital until discharge from the hospital fourteen days later, at which time resident returned to the long-term care home. Hospital discharge diagnoses included multiple medical diagnosis.

Director of Care indicated the home was not aware of Resident #062 having an injury, but was in agreement that Resident #062 had a significant change in health status post falls resulting in injury, continued pain, change in level of care needs, unresponsive incident which prompted assistance of 911 and admission to hospital for

a period of approximately two weeks, following the fall incidents.

The Director was not notified until eleven days after an incident that caused an injury to Resident #062, for which the resident was taken to hospital and which resulted in a significant change in a resident's health status. [s. 107. (3) 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 by ensuring the Director was immediately informed, in as much detail as is possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide.
-by ensuring the Director, was informed, no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 9 (1) 2, by not ensuring that all doors leading to non-residential areas, are locked when they are not being supervised by staff.

The laundry room, located in the basement, was observed to be propped open (with door stop) and left unsupervised (no staff present) on November 20, 2015, from 08:13 hours until 08:18 hours. There were washers and dryers in operation at the time of this observation; as well the laundry room contains chemicals and products for laundering purposes.

During a second observation, on November 20, 2015, at 12:11 hours until 12:18 hours, the laundry room door (in basement) was observed to be propped open, and no staff were in attendance in the laundry room.

A resident was observed in the Atrium (within close proximity to the laundry area) during the time of the second observation.

Laundry Aide #155 indicated (to the inspector) that the basement is considered a resident area (contains chapel, games room, hairdressers, atrium, library and chapel), but the laundry room is considered a non-residential area and is to be locked when staff are not in attendance.

Environmental Services Manager indicated (to the inspector) that doors to all non-residential areas are to be closed and locked whenever staff are not within the room. [s. 9. (1) 2.]

WN #12: 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. Related to Intake #07008-15, for Resident #046:

The licensee failed to comply with LTCHA, 2007, s. 20 (1), by not ensuring that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The home's policy, Resident Abuse – Staff to Resident (#OPER-02-02-04), directs that staff are to immediately report (verbally) any suspected or witnessed incidents of abuse/neglect to the Administrator or Director of Care, or their designate; in Ontario, in addition to the above, anyone who suspects or witnesses abuse/neglect that causes or may cause harm to a resident is required to contact the Ministry of Health and Long-Term Care.

The policy further directs that the Administrator, Director of Care and or designate will immediately notify any person required by law (Director) of incidents involving alleged, suspected or witnessed abuse.

The Director of Care, submitted a Critical Incident Report to the Director, on an identified date. According to details in the CIR Resident #046 was not administered any of the scheduled doses of pain medication, during an eight hour shift.

The medication administration record, as well as the narcotic record provides documentation, indicated that Resident #046 was without pain medication for eight hours, despite a physician's order for medication to be given every two hours.

A review of the home's investigational notes (including Critical Incident Report) and interviews with the Resident Care Area Manager (RCAM #151), who was in charge during the identified shift and the Director of Care all indicated that the incidents of failing to provide narcotic pain medication was considered 'neglect of care'.

RCAM #151 indicated being contacted by the oncoming shift RPN of the medication

incidents (missed medications), and RCAM #151 had contacted the Director of Nursing Services as to the incident (missed medications). RCAM #151 indicated (to the inspector) that the incident was considered neglect of care; RCAM indicated not contacting the Ministry of Health and Long-Term Care, as to the 'neglect incident' as it had been reported to the Director of Nursing Services; RCAM indicated being aware of the home's policy (Resident Abuse-Staff to Resident).

The home's policy, Resident Abuse-Staff to Resident, was not complied with as evidenced by the following:
- An incident involving alleged, suspected or witnessed neglect, which occurred on an identified date, was not immediately reported to the Director, by the Resident Care Area Manager (#151) nor the Director of Nursing Services.(554)

Related to Intake #016142-15, for Resident #051:

A Critical incident report (CIR) was submitted by the home on an identified date, following an in-service on resident abuse and reporting guidelines. PSW #127 reported to DOC that on an identified date, witnessing PSW #128 being physically abusive towards Resident #051. Both PSW #127 and #128 were providing care to the resident - the resident was agitated,resisting care and exhibiting responsive behaviours. PSW #128 grabbed the resident's cheeks, holding the resident's face back. PSW #128 was asked to leave the room by PSW #127. PSW #127 observed a bruise on the resident's cheek and reported it to the RPN #133 but, PSW #127 did not report the alleged abusive interaction with PSW #128 to the RPN or anyone else at the time.

During an Interview with DOC on November 24, 2015 at approx 11:00 hours, she acknowledged PSW #127 did not comply with the home's written policy by immediately reporting the alleged abuse incident.(552)

CIR was submitted to the Director for what the home catergorized as improper/incompetent treatment of a Resident #010. Physical abuse of Resident #010 was reported to the Director two days after the incident, contrary to the Abuse policy in the home.(570)

On November 17, 2015 during interviews with inspector #607, Resident #020 and Resident #003 indicated that missing money was reported to the Administrator of the home. The Administrator confirmed that the missing money was not report to the Director as directed in the licensee's abuse policy.(607)

CIR was submitted to the Director for what the home catergorized as improper/incompetent treatment of a Resident #058. Physical abuse of Resident #058 was reported to the Director two days after the incident, contrary to the Abuse policy in the home.(554)

A Compliance Order (CO #001), under LTCHA, 2007, s. 19, was issued during inspection #2015_360111_0014, which included a written notification (WN) specific to LTCHA, 2007, s.20 (1); the incidents involving Resident's #051 and #046 were prior to the compliance due date of August 15, 2015 but the incidents involving Resident's #020, #003 and #058 are after the compliance date therefore the order will be issued for a second time. [s. 20. (1)]

WN #13: 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. Related to Intake #015635-15, for Resident #054:

The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Critical Incident Report submitted by the home on an identified date indicating that a non staff member approached the Director of Nursing Services to report that another non staff member had witnessed an incident involving a resident the day before. During the interview, the non staff member reported the resident was crying loudly and resisting care. The resident continued to cry out and resist having care provided. The staff member continued to provide the care despite the residents resistance.

During an interview on November 24, 2015, DOC explained that an investigation into the alleged incident was immediately commenced. Following the investigation conducted by the home, the home was unable to determine if the alleged abuse had occurred but had made the decision to take disciplinary actions towards the PSWs. The Director was not notified of the outcome of the investigation into the abuse incident.

The DOC acknowledges that the ministry should have been informed of the outcome.

Related to Intake #016142-15, for Resident #051:

A Critical incident report (CIR) was submitted by the home on an identified date, following an in-service on resident abuse and reporting guidelines. PSW #127 reported to DOC that on an identified date, witnessing PSW #128 being physically abusive towards Resident #051. Both PSW #127 and #128 were providing care to the resident - the resident was agitated,resisting care and exhibiting responsive behaviours. PSW #128 grabbed the resident's cheeks, holding the resident's face back. PSW #128 was asked to leave the room by PSW #127. PSW #127 observed a bruise on the resident's cheek and reported it to the RPN #133 but, PSW #127 did not report the alleged abusive interaction with PSW #128 to the RPN or anyone else at the time.- only that the resident had a bruise.

During an interview with DOC on November 24, 2015 at approx 11:00 she explained during the investigation, head to toe assessment was completed for the resident, there were no marks or bruises observed. The resident was unable to verbalize that the incident had occurred. The home was unable to determine the incident had occurred but the accused PSW was provided with education on resident bill of rights, GPA and responsive behavior. The DOC acknowledges that the results of the abuse investigation was not reported to the Director.

A Compliance Order (CO #001), under LTCHA, 2007, s. 19, was issued during inspection #2015_360111_0014, which included a written notification (WN) specific to LTCHA, 2007, s. 23 (1)(a)(b); the incident involving Resident #054 and # 051 was prior to the compliance due date of August 15, 2015. [s. 23. (2)]

WN #14: 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 the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

For the purpose of the definition of "abuse in subsection 2(1) of the Act, "financial abuse", means any misappropriation or misuse of a resident's money or property.

During an interview with resident #020 on November 17, 2015, the resident brought forward concerns that a total of $270.00 went missing from his/her wallet about three weeks prior, and that this was reported to the Administrator. Resident #003 also brought forward concerns that $40.00 went missing during the night and this was reported. A review of the home's complaint log could not locate any documented record in relation to the above concern for resident #020, but there was documented record for resident #003's missing funds. A review of the home's record could not locate a report submitted to the Director in relation to the above identified missing

funds. An interview with the Administrator confirms that he did not complete or submit a report regarding the above identified concerns to the Director.(607)
[s. 24. (1)]

2. The licensee failed to comply with LTCHA, 2007, s. 24. (1), by not ensuring 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, specifically as it relates to:

For the purpose of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means, the use of physical force by anyone other than a resident that causes physical injury or pain.

Related to Intake #032511-15, for Resident #058:

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident of physical abuse, which the home categorized as being "improper/incompetent treatment of a resident that results in harm or risk to a resident".

The Critical Incident Report indicated that on an identified date, two Personal Support Workers were transferring Resident #058, using a mechanical ceiling lift from wheelchair to bed, during the transfer Resident #058's medical equipment became entangled around the mechanical ceiling lift's arm bar, pulling on the medical equipment, which resulted injury to Resident #058; resident was transferred to hospital for assessment and treatment.

Director of Care indicated to the inspector the incident and subsequent injury to Resident #058 resulted from Personal Support Workers #162 and #163 not following the home's Safe Lifts and Transfers policy and practice.

Director of Care (DOC) indicated to the inspector that she was informed, by the Resident Care Area Manager, of the incident. DOC indicated that the Director was not immediately informed of the physical abuse, as she was directed by the Administrator to wait until the next day to speak with the home's Consultant (Extendicare Assist). Director of Care indicated, she is aware that the CIR was late being reported to the Director.

The Director was not informed of the physical abuse that resulted in harm to the

resident until two days later.(554) [s. 24. (1)]

3. Related to Intake #015525-15, for Resident #010:

A critical incident report was received on an identified date for an incident of improper/incompetent treatment of a resident that results in harm or risk to a resident.

The CIR indicated that on an identified date, PSW reported that resident #010 had sustained an injury. PSW stated that when the staff pulled the Geri chair forward, the resident sustained an injury.

During an interview, the DOC indicated that the CIR was reported by the former DOC and that if the incident was called in the MOHLTC it would be documented on the CIR and the progress notes.

Review of the CIR notes and clinical records of resident #010 indicated no documentation that the incident was immediately reported to the Director. The CIR was submitted to the Director two days after the incident.(570)

Related to Log # 019428-15 for Resident #057:

A critical incident report (CIR) was received on an identified date for an incident of improper/incompetent treatment of a resident that results in harm or risk to a resident.

The CIR indicated that, swelling and bruising was noted on resident #057's chest. The location of the bruising on the resident's chest led to the belief that the arm of the mechanical lift struck the resident's chest during transfer from bed to wheelchair.

Review of clinical records of resident #057 indicated that RN #105 called in the incident to MOHLTC two days after the incident.

The DOC confirmed that the incident was not reported immediately to the Director. (554)

Related to Intake #007008-15, for Resident #046:

Under O. Reg. 79/10, s. 2 (1), 'neglect' is defined as the failure to provide a resident

with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The Director of Care, submitted a Critical Incident Report to the Director on an identified date, specific to an incident of neglect of care; the incident was said to have occurred two days earlier.

Details of the CIR as a follows:
- Resident #046 who was palliative at the time, and struggling with comfort and pain control, was ordered pain medication subcutaneously (SC) every two hours; Resident #046 did not receive any pain medication for eight hours.

According to the home's investigational notes, the Director of Nursing Services received a call from Resident Care Area Manager (RCAM), indicating that Resident #046 did not receive four scheduled doses of pain medication during an identified eight hour shift.

Resident Care Area Manager (RCAM), who was the supervisor, on site at the home, when the incidents of missed pain medication was discovered indicated (to the inspector) that not administering pain medication to Resident #046 who was palliative and struggling with pain control was considered neglect of care; RCAM indicated not reporting the neglect of care incident to Ministry of Health and Long-Term Care, as it had been reported to the Director of Nursing Services; RCAM indicated it is the practice of the home, that nursing managers (Director of Care or Director of Nursing Services) would report incidents of alleged, suspected or witnessed abuse and or neglect to the Director.

Director of Care (DOC) indicated (to the inspector) she did not submit the Critical Incident Report (CIR) to the Director until two days later, as that is the date in which she was notified of the incident; DOC indicated (to the inspector) that a resident not receiving scheduled pain medication would be considered neglect of care and should have been immediately reported to the Director.

The neglect of care incident was not immediately reported to the Director, despite the Director of Nursing Services being aware of the incident on two days previous, as reported by the RCAM.(554)

A Compliance Order (CO #001), under LTCHA, 2007, s.19, was issued during

inspection #2015_360111_0014, which included a written notification (WN) specific to LTCHA, 2007, s.24(1); the incidents involving Resident's #010,#057 and #046 were prior to the compliance due date of August 15, 2015, but incidents involving Resident's #020, #003 and #058 were after the compliance date therefore the Order will be issued for a second time. [s. 24. (1)]

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The Licensee has failed to comply with LTCHA, 2007 S.O. 2007c.8., s.44 Authorization of admissions to the home

Specifically fail to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

Related to Intake #004080-15, for Resident #067:

On November 26, 2015, the inspector spoke with the home's Administrator regarding a letter sent to Community Care Access Center (CCAC) dated August 27, 2014 regarding the refusal of the application for applicant #067 to the home. The Administrator explained that applicant #067's application to the home was not accepted because of the applicant's dietary care needs and the home was unable to accommodate the applicant needs. The Administrator acknowledged refusal of Resident #067 did not meet the criteria outlined in the the legislative requirements. [s. 44. (7)]

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that written response is provided within 10 days of receiving Resident's Council advice related to concerns or recommendations.

On November 24, 2015 at 1450 hours interview of the Residents' Council President indicated that written responses to concerns identified at the meeting are not provided to the council within 10 days. The written responses are provided to the council at the following meeting when those concerns are discussed. The Residents' Council President indicated that no written responses provided to concerns identified in the minutes of October 27, 2015.

Review of the Resident Council Meeting minutes of October 27, 2015 indicated no written responses to the following concerns:
- Concerns related to Nursing and Personal Care: Resident stated that PSWs don't always want to get (the resident) ready; Staff are noticed to sleep in residents areas Residents stated that management should be coming to meetings they have been passing the invitation off to other staff in the department.
- Concerns related to environmental services: Unclean hallways; Maintenance student not wearing name tag and entering residents' rooms without permission.
Volunteers are not wearing name tags and using cell phones during their hours.
- Concerns related to Nutrition and hydration care: residents are not getting many choices in snacks; residents are getting same thing; same thing on the menu is offered all the time; residents find it hard to get things from the kitchen when they ask.

Review of the Resident Council Meeting minutes of August 21, 2015 indicated written responses were not provided within 10 to the following concerns:
- Concerns related to Nursing and Personal Care: PSWs and other staff are just walking into residents rooms without knocking first (written response dated September 24, 2015 to Residents Council concern form dated August 31, 2015); Call bells are not answered in timely manner; PSW staff state they will come back and forget (written response dated September 24, 2015 to Residents Council concern form dated August 31, 2015). After hours door bell is not being answered promptly by the Linden staff.

(written response dated September 23, 2015 to Residents Council concern form dated August 31, 2015).
- Concerns related to Restorative care: restorative have been short staffed needed to cover staff in different departments; (written response dated September 23, 2015 to Residents Council concern form dated August 31, 2015).

On November 26, 2015 at 1100 hours interview with Director of Programs indicated that written responses to concerns are not provided to the Residents' Council after management responds to identified concerns using the Resident Council Concern Form. Those forms are held till the next Residents' Council meeting when the concerns forms are reviewed by the council. [s. 57. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who require assistance with eating or drinking only served a meal when someone is available to provide the assistance.

On November 23, 2015 during supper meal, Resident #061 was observed to be served an entree in advance of assistance being provided. The resident did not initiate eating the meal on his/her own. Resident is known to staff to require total assistance with feeding. Resident's plan of care related to eating identified that the resident requires total assistance for eating. An interview with the DOC and the nutrition manager confirmed that residents who require total assistance food should not be placed in front of the resident until a PSW is available to assist the resident [s. 73. (2) (b)]

WN #18: 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 are stored in an area or a medication cart,
ii. that is secure and locked.

On November 20, 2015 @ 09:00 hours it was noted that the medication storage area on the Maple unit was left unlocked and accessible. Noted by the inspector inside the cupboard was the following:
-two bottles of Tylenol 325 mg tablets.
-bottles of Lactulose
-bottles of Colace liquid
-one bottle of Koffex
-one bottle of Bronchophan expectorant
-bottles of alcohol
-the medication destruction tub for the unit, with numerous medications inside. [s. 129. (1) (a)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. Related to Intake #0028395, for Resident #029:

The licensee has failed to ensure that appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs.

On an identified date Resident #029 was given another resident's medication in error by RPN #134. RPN #135 who was carrying medications for another resident, walked by Resident #029's room and observed Resident #029 on the floor. RPN #135 entered the room to ensure resident was safe. RPN #134 also entered the room and was instructed by RPN #135 to watch the medication cup which was placed out of the resident's reach, while RPN #135 called for help. When RPN #135 returned to the room RPN #134 had given the medications to resident #029.

Resident #029 was given two different muscle relaxants , pain medication and laxative in error.

RPN #135 administered the 12:00 hours scheduled medication pass to Resident #029 which included pain medication, iron and an antipsychotic medication.

Resident # 29's blood pressure was monitored between 10:20 and 13:20 and noted to be dropping, no other Blood pressure was noted until 15:00 hours. Progress notes indicate that Resident #029's Vital signs at 15:00 hours indicated blood pressure was low and resident condition was changing, Resident was difficult to rouse. At 15:30 hours, resident's condition deteriorated, writer unable to rouse resident. Supervisor present and called MD. MD agreed to sent to hospital.

During the evening shift it is documented in the progress notes that the resident's blood pressure dropped causing the home to call the ambulance, but the resident stabilized before being transferred and stayed at the home. [s. 134. (b)]

Issued on this 19 day of April 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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347 Preston St, Suite 420
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : CHANTAL LAFRENIERE (194) - (A1)

Inspection No. / No de l'inspection : 2015_365194_0028 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 031205-15 (A1)

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

Report Date(s) / Date(s) du Rapport : Apr 19, 2016;(A1)

Licensee / Titulaire de permis : CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD : Orchard Villa
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Gary Hopkins

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To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_360111_0014, CO #001;

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 that:

-The establishment of an effective communication protocol between Extendicare Assist and the senior management at the home related to reporting incident of abuse is implemented. The communication protocol will ensure that;

1. The Director is immediately notified of all incidents of abuse at the home. (as noted in WN#14)
2. Further education to senior management team to ensure clear understanding of current abuse policies in the home.(as noted in WN#13)

-A monitoring process is in place to assess the effectiveness of the communication protocols between Extendicare Assist and the senior management at the home, including a method;

- whereby DOC and or delegate is reviewing all communication from the front line staff to determine if any abuse has occurred in the home.

-whereby appropriate and timely follow up for any incidents of abuse documented or reported, ensuring that all legislative requirements have been fulfilled.

-whereby the licensee's Abuse policy is complied with.

- Monthly analysis of all incidents of resident abuse is completed to identify and address any deficiencies.

Grounds / Motifs :

1. A Compliance Order (CO #001), under LTCHA, 2007, s. 19, was issued during inspection #2015_360111_0014, which included a written notification (WN) specific to LTCHA, 2007, s. 24 (1); with a compliance date of August 15, 2015

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident, has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

For the purpose of the definition of "abuse in subsection 2(1) of the Act, "financial abuse", means any misappropriation or misuse of a resident's money or property.

During an interview with resident #020 on November 17, 2015, the resident brought forward concerns that a total of $270.00 went missing from his/her wallet about three weeks prior, and that this was reported to the Administrator. Resident #003 also brought forward concerns that $40.00 went missing during the night and this was reported. A review of the home's complaint log could not locate any documented record in relation to the above concern for resident #020, but there was documented record for resident #003's missing funds. A review of the home's record could not locate a report submitted to the Director in relation to the above identified missing funds. An interview with the Administrator confirms that he did not complete or submit a report regarding the above identified concerns to the Director.(as noted in WN #15)(607)

Related to Intake #032511-15, for Resident #058:

The licensee failed to comply with LTCHA, 2007, s. 24. (1), by not ensuring a person who has reasonable grounds to suspect that abuse of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, specifically as it relates to:

For the purpose of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means, the use of physical force by anyone other than a resident that causes physical injury or pain.

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident of physical abuse, which the home categorized as being "improper/incompetent treatment of a resident that results in harm or risk to a resident".

The Critical Incident Report indicated that on an identified date, two Personal Support Workers were transferring Resident #058, using a mechanical ceiling lift from wheelchair to bed, during the transfer Resident #058's medical equipment became entangled around the mechanical ceiling lift's arm bar, pulling on the medical equipment, which resulted injury to Resident #058; resident was transferred to hospital for assessment and treatment.

Director of Care indicated to the inspector the incident and subsequent injury to

Resident #058 resulted from Personal Support Workers #162 and #163 not following the home's Safe Lifts and Transfers policy and practice.

Director of Care (DOC) indicated to the inspector that she was informed, by the Resident Care Area Manager, of the incident. DOC indicated that the Director was not immediately informed of the physical abuse, as she was directed by the Administrator to wait until the next day to speak with the home's Consultant (Extendicare Assist). Director of Care indicated, she is aware that the CIR was late being reported to the Director.

The Director was not informed of the physical abuse that resulted in harm to the resident until two days later.(as noted in WN #15)(554) [s. 19. (1)] (194)

2. On November 17, 2015 during interviews with inspector #607, Resident #020 and Resident #003 indicated that missing money was reported to the Administrator of the home. The Administrator confirmed that the missing money was not report to the Director as directed in the licensee's abuse policy.(as noted in WN#13)

CIR was submitted to the Director for what the home categorized as improper/incompetent treatment of a Resident #058. Physical abuse of Resident #058 was reported to the Director two days after the incident, contrary to the Abuse policy in the home.(as noted in WN#12)

The decision to issue an order is based on three separate incidents in November 2015, where under the legislative requirements, immediate notification to the Director was to be completed and the licensee failed to report. In two of the incidents significant amounts of money were reported by residents to be missing and the third incident resulted in actual harm to the resident. During the inspection an additional three incidents of non compliance related to reporting of abuse were identified, prior to the compliance date of the existing order. In all of the examples of abuse identified during the inspection the licensee has failed to follow their Abuse policy. A Compliance Order (CO #001), under LTCHA, 2007, s. 19, was issued during inspection #2015_360111_0014, which included a written notification (WN) specific to LTCHA, 2007, s. 24 (1); with a compliance date of August 15, 2015. (194)

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

Apr 30, 2016

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

Linked to Existing Order / Lien vers ordre existant: 2015_293554_0009, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

the licensee shall ensure:

- To implement measures and a monitoring process to ensure that the care set out in the plan of care is based on an assessment of the resident's needs, especially for those residents with a change in condition. That appropriate and timely action is taken when the needs of the resident(s) are not being met at the home.

- to provide re-instruction to all registered nursing staff of the importance of following the home's policies, specifically "Urinary Catheterization" and "Removal of an indwelling Catheter" policies, especially when a resident is exhibiting a change in health status.

Grounds / Motifs :

1. A Compliance Order (CO #001), under LTCHA, 2007, s. 6 (2) was issued during inspection #2015_293554_ 0009, specific to the care set out in the plan of care being based on an assessment of the resident's needs and preferences, with a compliance date of August 14, 2015.

Related to Intake #032511-15, for Resident #058:

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident, which the home indicated as being 'improper/incompetent treatment of a resident that results in harm or risk to a resident'.

Details of the Critical Incident Report are as follows:
- Personal Support Worker (PSW) #162 and #163 were transferring Resident #058 from wheelchair to bed, using a mechanical ceiling lift (and sling). PSW's transferred Resident #058 into bed, attached the resident's medical equipment the left side of the bed, while one staff attempted to remove the sling from under Resident #058, the second PSW, using the hand held control, returned the mechanical (ceiling) lift to its resting position; while the mechanical ceiling lift was returning to its resting position, PSW #162 and #163 heard Resident #058 cry out; PSW's observed that Resident #058's medical equipment had been entangled on the mechanical (ceiling) lift's arm, PSW stopped the lift, observing resident was in discomfort and bleeding.

Registered Nursing Staff assessed Resident #058 following the incident; resident continued to experience bleeding and pain. Registered Practical Nurse (RPN) #113 and Registered Nurse (RN) #152 attempted to provide nursing interventions, but attempts were unsuccessful. Registered Practical Nurse #113 reported to the Registered Nursing-Supervisor #153 that attempts to provide nursing interventions were unsuccessful, RPN #113 and RN #152 were instructed by RN-Supervisor #153 to wait fifteen minutes and to attempt again.

Registered Nurse #152 and Registered Nurse-Supervisor #153 indicated (to the inspector) that Resident #058 was experiencing discomfort and bleeding following the transferring incident, both registered nursing staff indicated that Resident #058 continued to experience bleeding and discomfort when registered nursing staff were attempting to provide nursing intervention. Both registered nursing staff (#152 and #153) indicated that the doctor was not contacted for direction as Resident #058 advanced directives were noted as a Level 2, indicating resident was to be cared for in the home.

As per the progress notes, an hour and a half later, Resident #058 was observed to have a change in condition with vital signs decreasing; resident was transferred to hospital for assessment.

The hospital discharge summary indicated, Resident #058 was assessed and referred to a specialist while at the hospital. Resident #058 was transferred back to the long-care home later that day.

The Critical Incident Report indicates Resident #058 returned to the home and was

found deceased four hours later.

Director of Care indicated (to the inspector) that Registered Nursing Staff should have contacted Resident #058's attending physician (or transferred resident to hospital), for further assessment due to the transfer incident, subsequent injury and when resident continued to experience bleeding and or staff's inability to provide nursing interventions.

The licensee failed to ensure that the care set out in the plan for Resident #058 was based on an assessment of the resident's needs. When the resident was not provided with an opportunity to be assessed by the physician or transferred to the hospital for assessment related pain management, bleeding and the inability of Registered staff to provide the nursing interventions for a period of one hour and fifteen minutes

The decision to issue an order is based on Resident #058's actual harm during care and the resulting change in condition, a past history of non compliance in this area resulting in an Order being issued in report # 2015_293554_ 0009. There is continued evidence that care set out in the plan of care is not based on the assessment and needs of the resident with a change in condition.
(554)

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

Feb 29, 2016

Pursuant to / Aux termes de :

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

Order / Ordre :

The home shall ensure that all staff use safe transferring and positioning devices or techniques when assisting residents by ensuring;

-re-education of staff related to the licensee's "Safe Lifting with Care Program, specifically the Mechanical Lift Policy (#01-03).
-re-education of staff related to residents requiring specific transferring techniques for safety.

Grounds / Motifs :

1. Related to Intake #032511-15, for Resident #058:

The licensee failed to comply with O. Reg. 79/10, s. 36, by not ensuring staff use safe transferring and positioning devices or techniques when assisting the resident.

The home's policy, Mechanical Lifts (#01-03) directs that prior to all transfers the arm rests and footplates are to be removed from the receiving surface (e.g. wheelchair); staff are to complete a Pre-Transfer Review, which includes resident readiness, staff readiness, environment readiness and equipment readiness, if any deficiencies are identified or suspected staff are not to proceed with the transfer and to notify the supervisor.

The home's policy (Mechanical Lifts) directs that prior to a transfer (using a mechanical lift) both staff members are to complete the 6 Point Checklist (#01-12) which is attached to the lift (which includes, is resident able to participate in the lift, is the sling applied correctly, is the sling attached to the lift correctly, is the lift path clear and are both staff members ready and positioned correctly to complete the lift. The policy (Mechanical Lift) directs that once the 6 Point Checklist is completed the resident is to be lifted two-three inches above the departing surface (e.g. wheelchair) and staff are to once again check that the sling is positioned properly, resident is

comfortable, resident is balanced under the lift mechanism, and if any deficiencies are identified resident is to be lowered, sling re-applied and 6 Point Checklist is to be completed again. The policy (Mechanical Lift) directs that the resident is to be protected from touching any part of the mechanical lift or other equipment. The home's policy (Mechanical Lift) further directs that once the resident is lowered onto the receiving surface (e.g. bed) staff are to ensure resident is comfortable and positioned correctly, then to unhook sling and return ceiling lift to the charge (docking station).

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident, which the home indicated as being 'improper/incompetent treatment of a resident that results in harm or risk to a resident'.

Details of the Critical Incident Report are as follows:
- Personal Support Worker (PSW) #162 and #163 were transferring Resident #058 from wheelchair to bed, using a mechanical ceiling lift (and sling). PSW's transferred Resident #058 into bed, attached the medical equipment onto the left side of the bed, while one staff attempted to remove the sling from under Resident #058, the second PSW, using the hand held control, returned the mechanical (ceiling) lift to its resting position; while the mechanical ceiling lift was returning to its resting position, PSW #162 and #163 heard Resident #058 cry out; PSW's observed that Resident #058's medical equipment had been entangled on the mechanical (ceiling) lift's arm, PSW stopped the lift, observing resident was in discomfort and bleeding.

Personal Support Worker #163 indicated (to the inspector) that along with PSW #162 they were transferring Resident #058 from the wheelchair into bed; PSW #163 indicated that they had attempted to place the transferring sling under Resident #058 while the resident was in the wheelchair but that the placement of the sling was difficult due to Resident #058 refusing to allow the wheelchair arms to be removed and that the space between the bed and wheelchair was small, making placement of the sling difficult. PSW #163 indicated that they had asked Resident #058 to hold onto the transfer sling handles and other medical equipment while they (PSW #162 and #163) proceeded to transfer resident from chair to bed. PSW #163 indicated that once resident was in the sling, PSW #163 moved to the opposite side of the bed and pushed the start button (ceiling lift control); PSW #163 indicated that while the ceiling lift was still in motion (resident was over the bed), PSW #163 attempted to remove resident's shoes while still operating the lift, and it was during this time that Resident

#058 began to scream. PSW #163 indicated that the medical equipment was caught on the sling handles and handles of the ceiling lift and was accidentally pulled when transferring the resident from wheelchair to bed.

Personal Support Worker #163 indicated (to the inspector) that PSW #163 and PSW #162 should have followed the home's safe transfer and lifting procedures while transferring Resident #58; PSW #163 indicated that they (PSWs) did not removed the wheelchair arm rests prior to the transfer making it difficult to place the sling under the resident and making it difficult to clearly visualize the transfer pathway; PSW #163 further indicated that Resident #058 should have been safely positioned in bed prior to removing the shoes or sling and that they (PSWs) should have been more aware of where resident's medical equipment placement prior to and during the transfer (with ceiling lift). PSW #163 indicated that PSW #163 and PSW #162 did not complete the 6 Point Checklist prior to transferring Resident #058.

The Director of Care indicated (to the inspector) that "Personal Support Workers #162 and #163 were not following the home's Safe Lifting with Care Program", specifically the Mechanical Lifts Policy (#01-03) "which contributed the incident and subsequent injury of Resident #058".

DOC indicated that PSW's #162 and #163 did not follow the home's Safe Lifting with Care Program, by not doing the following:
- remove the arm rest of Resident #058's wheelchair; indicating it is the home's policy and practice that the arm rest of the wheelchair is to be removed with all transfers involving the use of a mechanical lift, as it creates a 'blind spot' and that potentially items could become entangled around the arm of wheelchair;
- complete that six-point checklist prior to and during use of a mechanical lift, specifically PSW #162 and #163 did not ensure the mechanical lift path was clear; during the incident, Resident #058's medical equipment became entangled in the handle of the lift, and when returning the lift to its charge (docking station).
- and that following the transfer of Resident #058 from wheelchair to bed, PSW's #162 and #163 did not ensure resident was properly positioned before returning the ceiling lift to the charge (docking station).

Director of Care indicated (to the inspector) that it is the expectation that all staff, who have been trained to use the mechanical lifts are to follow the home's Safe Lifting with Care Program.

(554)

2. Related to Intake #015525-15, for Resident #010:

A Critical incident report indicated that on an identified date. PSW stated that when the staff pulled the Geri chair forward, resident #010 suffered an injury.

Review of the plan for Resident #010 in effect at time of incident indicated the resident has multiple diagnoses including Cognitive Impairment, is totally dependent in transferring, and fragile skin.
The plan of care related to transferring, skin integrity and comfort directs to staff to:
-Put pillows on both sides of the resident's elbows when sitting in the wheelchair/lounge chair to prevent injury.
-Assess resident's ability to transfer safely prior to each transfer.
-Protect pressure areas with pillows and heel poseys.
Resident #010's progress notes were reviewed. On an identified date RPN #188 documented that, PSW reported an injury was sustained to Resident #010. Possible cause: as per staff, when pulled up the Geri chair, resident was injured.
Interview with PSW #186 indicated that PSW #186 and PSW #187 were preparing the resident to be transferred from Geri chair to bed; PSWs removed the pillows from both side of the resident. PSW #186 indicated to inspector #570 during an interview that when the staff moved the back of the chair forward from reclining to a sitting position the back of the chair snapped back; then realized that the resident's limb was caught between back of chair and arm rest. PSW #187 should have protected the resident's limb at the time; PSW #187 indicated the chair is an old style and was not orientated on how to use it and realized after the incident the need to push the foot rest of the chair backwards for the back of the chair to lock in position.

Review of investigation notes and statement by PSW #187 indicated the staff removed the right pillow first, as the staff turned around the resident's limb was down on the side of the chair. When moving the resident limb gently blood was noticed and RPN was called. PSW #186 was on the other side of the chair. RPN #188 indicated before pulling the Geri chair forward, PSWs #186 and 187 removed the pillows and they had been instructed that they pull the pillows out last.

Review of the investigation notes and plan of care for resident #010 indicated the

PSW staff did not ensure the resident's safety when removing supporting/protective pillows while preparing the resident to transfer from chair to bed.(570)

The decision to issue an order is based on two critical incidents occurring in the home between June and November 2015 where improper transfers were completed by staff resulting in actual harm to residents. (570)

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

Feb 29, 2016

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Order / Ordre :

The licensee shall:

- Develop an implement a process to ensure that medication is administered to all residents in accordance with the directions for use, as specified by the prescriber; and

- Develop an implement a process to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

-Educate all registered nursing staff related to the College of Nurses of Ontario Medication Practice Standard, including administration of narcotics and appropriate action to be taken in response to any medication error.

-Development of a formal monitoring process to evaluate medication administration processes to promptly address medication administration issues
and avoid adverse medication incidents

Grounds / Motifs :

1. Related to Intake #0028395, for Resident #029:

The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

On an identified date Resident #029 was given another resident's medication in error by RPN #134. Resident #029 had a fall and was found by RPN #135 who was carrying medications for another resident when the RPN walked by Resident #029's room and found the resident on the floor. RPN #135 entered the room to ensure resident was safe, and RPN #134 also entered the room and was instructed by RPN #135 to watch the medication cup which was placed out of the resident's reach, while RPN called for help. When RPN #135 returned to the room, RPN #134 had given the medications to resident #029.

Subsequently Resident # 029 experienced a significant drop in blood pressure. [s. 131. (1)]

2. Related to Intake #007008-15, for Resident #046:

The licensee failed to comply with O. Reg. 79/10, s. 131 (2), by not ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A review of the clinical health record, for Resident #046, for the period of ten days, indicates that resident had been deemed palliative; according to progress notes, physician's orders and interviews with a Resident Care Area Manager and the Director of Care, Resident #046 was having difficulties with pain control.

On an identified date, Resident #046's attending Physician prescribed a STAT pain medication to be given subcutaneously; then routinely, subcutaneously every two hours for comfort.

According to a Critical Incident Report, Resident #046 was not administered any of the scheduled doses of pain medication, during an eight hour shift, despite a physician's order for medication to be given every two hours.

Director of Care indicated (to the inspector) that the medication incident was investigated and it was found that Registered Practical Nurse #114 who was the assigned charge nurse, did not only not administer the prescribed pain medication to Resident #046 during the identified shift, but also missed a scheduled dose of pain medication, for Resident #046, the following day.

According to the Director of Care, Registered Practical Nurse (RPN) #114 indicated Resident #046 was asleep and since resident was sleeping, the RPN felt that the medication was not required.

Director of Care indicated that Registered Practical Nurse #114 should have awakened Resident #046 to administer the pain medication especially noting resident had been experiencing pain control and management difficulties, and indicating the physician ordered the medication to be given every two hours.

2) Related to Resident #043:

According to the physician's orders, Resident #043 was prescribed pain medication every eight hours, for pain control.

A medication incident report, as well as the medication administration record and narcotic administration record, for Resident #043, provides documented evidence that Registered Practical Nurse #114 failed to administer the prescribed dose of pain medication to Resident #043 on an identified date.

Registered Practical Nurse #114 indicated to the Director of Care, that she had forgotten to administer the pain medication to Resident #043.

Director of Care indicated (to the inspector) the expectation is that physician's orders are to be followed as directed. [s. 131. (2)]

The decision to issue an order is based on Resident #29 receiving medications not prescribed for the resident resulting in a drop in blood pressure and ambulance to be called to the home. Residents #043 and # 046 not receiving narcotics as prescribed resulting in pain to the residents. The three separate incidents have occurred between April to October 2015. (194)

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

Feb 29, 2016

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

The licensee shall ensure that;

- A monitoring process is in place to assess the effectiveness of the housekeeping and maintenance practices in the home. The monitoring process will include a method;

-to ensure that the "deep cleaning policies and practices for the home are implemented and complied with.(as noted in WN #7)
-to ensure that re-education is provided, to all departments related to the process for "PM Works", which is the electronic Maintenance requisitions used in the home.(as noted in WN#7)
-to ensure that the ESM is conducting weekly audits related the home furnishings and equipment being kept clean, sanitary, safe and in a good state of repair.
-Monthly analysis of all PM works received, is completed to identify and address any deficiencies.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (a), by not ensuring that the home, furnishings and equipment are kept clean and sanitary.

The following observations were made, during the dates of November 16, to November 20, and November 23 to the 24, 2015:
- Toilets – dark blackish-brown staining was observed surrounding base of toilet (stool) and the surrounding flooring in multiple resident washrooms and in the Birch/Maple, Pine and Linden tub/shower rooms;
- Floors – multiple resident rooms were observed to have dark brownish-black build

up (query grout or dirt) along flooring seams, flooring thresholds (transition piece from hall to resident room, or resident room to washroom) and along wall/flooring edges (especially in corners), as well as in the activity room adjacent to Pine, Pine and Linden lounges, resident home area hallways (Maple, Pine, Birch and Linden), as well as the Linden and Pine tub/shower rooms. The brownish-black build up could be scraped off when scraped with a pen, by the inspector;
- Floors – visible dust and debris, especially in corners of rooms were observed in the activity room and kitchenette adjacent to Pine (resident home area), in the Pine lounge, in the Linden and Pine tub/shower rooms and in the Atrium (basement);
- Vents – observed to have thick grey film to ceiling vent in the Linden tub/shower room; observed to have blackish film on and around the ceiling vent in the Birch lounge;
- Windows / Door – cob-webs were observed lining the inside of the window and doorway of the activity room adjacent to Pine (resident home area); as well as the window located at end of the Birch (resident home area) corridor;
- Commode – observed to have brownish staining smeared along edges of commode seating and on commode rails in two resident washrooms.
- Privacy Curtain – was observed stained along the width of the curtain panel in a resident room.

Environmental Services Manager (ESM) indicated awareness of floors in the home being soiled and in need of cleaning, especially in common areas of the home, and indicated (to the inspector) that Housekeeping Staff had not been following the 'deep cleaning policies and practices' and such has resulted in cleanliness issues throughout the home. ESM indicated (to the inspector) that a new roll-out schedule, for deep cleaning, is being introduced to housekeeping staff week of November 26, 2015.

Environmental Services Manager indicated the expectation is that the home, furnishings and equipment are kept clean and sanitary. [s. 15. (2) (a)]
(554)

2. Related to Intake #009024-15 and #010570-15:

The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a

good state of repair.

An anonymous complainant contacted the Ministry of Health and Long-Term Care's Action Line indicating that windows in the Pine resident home area and in the Pine tub/shower room were broken and in need of repair. The anonymous complainant indicated that cloths were being shoved into the window opening to prevent cold air from coming into resident rooms and or tub/shower room. The anonymous caller indicated reporting this concern to the management of the home without resolution.

Window latches (opening mechanism) on windows located in the Pine tub/shower and in the activity room (adjacent to Pine) were observed broken and unable to be closed during the dates of November 16, and again November 20, 2015.

Environmental Services Manager indicated (to the inspector) that he was not made aware of the window latches being broken, until he noticed it himself on November 20, 2015; ESM indicated (to the inspector) he relies on staff (nursing and housekeepers) to alert him of deficiencies and areas in need of repair via the PM Works (electronic maintenance requisitions).

2) The home's policy, Preventative Maintenance – Maintenance Program Overview (#MNTC-01-01-01) direct that the maintenance program will maintain the building (and equipment) in a condition that provides a safe, comfortable and pleasant environment for the residents.

The following observations were made during the dates of November 16, through to November 20, 2015:
- Walls: were observed scraped, gouged, paint chipped or having wall damage (dry wall exposed, holes or corner steel beading exposed) in multiple resident rooms or washrooms; in lounges located on Pine, Linden, Birch, Aspen and Cedar; in tub/shower rooms located on Birch/Maple, Pine, Linden, Asphen and Cedar; along hallways in Pine, Asphen, and Cedar;in the main dining room; and on the wall under the severy in the Cedar dining area was 'rippled' in appearance (query water damage);
- Tiled Walls: the ceramic tiled walls in tub/spa rooms located on Linden, Asphen and Cedar were observed cracked, chipped or having missing wall tiles; areas were wall tiles were chipped and or missing were noted to have jagged edges which were sharp; the lower edges of the wall tiles (along shower stall) and laminate flooring in the Linden, Cedar and Asphen tub/shower rooms were noted to have a blackish,

moist substance along the length of the shower stall (this concern was reported to the Environmental Services Manager by the inspector, as such poses a potential infection control issue);
- Doors and Door Frames: were observed to be chipped, paint missing, holes or having jagged metal edges on doors or door frames in resident rooms/washrooms and in the lounges located on Birch, Linden and Pine;
- Closets: were observed scraped (blackish marks) and or being off the track in resident rooms.
- Wall Guard – observed loose or missing in multiple resident rooms.
- Curtains: observed to be thread-bear (worn) or having the rubber backing of the curtain cracked or torn in resident rooms;
- Counter-top Vanities: were observed chipped (exposed porous surface) or missing laminate missing in multiple resident washrooms; in the main dining room on and around the hand-sink vanity and along the severy counter;
- Chairs: home owned chairs were observed to be chipped, worn (shellac finish missing) and having blackish staining on the chair legs in resident rooms;
- Sink Vanity: the metal legs attached to the counter-top vanities in resident washrooms were observed stained (blackish) or having areas of corrosion or rust, in washrooms located in resident rooms;
- Commodes and or Shower Chairs: were observed with rusted areas or corrosion in a resident washroom and in the tub/shower room on Linden;
- Toileting Safety Rails: rust was observed on the toileting hand rails in washrooms;
- Bedside Tables: were observed to be chipped (porous surface exposed) or missing laminate surround, in resident rooms;
- Bed-rails: were observed to have paint chipped along the railing in resident rooms;
- Transfer Pole: was observed rusted, this transfer pole was located in the Pine tub/shower room;
- Baseboard Heater (rad): was observed to have the radiator cover missing in a resident room;
- Foot board (beds): observed to have the laminate lifting along the foot board edges in a resident room;
- Towel-bar: observed to be missing in resident washrooms; in all three rooms the steeling casing in place to hold the towel bar was still present and noted to have sharp edges;
- Flooring: laminate flooring was observed gouged, chipped, cracked, torn, having holes and or lifting in areas, in multiple resident rooms or washrooms; in tub/shower rooms located on Linden, Pine, Asphen and Cedar; in the hallways on Maple and Birch; foyer entry (flooring threshold) leading from Birch into Cedar; and in the activity

room (adjacent to Pine); uneven flooring poses a trip fall hazard;
- Flooring: ceramic tiled floor was observed chipped and cracked in the main foyer of the home; the brick (stone) flooring was chipped in areas of the atrium (solarium) near the stairs; and the cement threshold leading from the atrium (solarium) into the games room was observed uneven;
- Flooring – laminate flooring in the Asphen tub/shower room was observed to be lifting in areas around the floor drain, this same area was 'soggy' feeling when the inspector stepped on it and water gushed out of the flooring from around the metal floor drain; the metal floor drain was covered with a black, moist substance; this room was noted to have a stale smelling odour (this was reported to Environmental Services Manager by the inspector, as such poses a potential infection control issue);
- Metal Blinds – observed bent (several horizontal sections) in the Pine lounge;
- Window Screen: in activity room (adjacent to Pine) was observed torn, the frame of the screen was bent and hanging from window;
- Light – one light in the Birch lounge was out (not working) during the dates of November 16-19; this room was dimly lit during the dates identified.

Housekeeping Aides, Personal Support Workers and Registered Nursing Staff all indicated (to the inspector) that staff are to utilize PM Works to communicate maintenance repairs required within the home when observed; nursing staff interviewed indicated that they normally only use PM Works for equipment repairs or equipment, and or furnishings that are broken; nursing staff indicated (to the inspector) that they do not use PM Works to address wall and or flooring problems to maintenance, as they felt maintenance were aware of repairs (maintenance) needed within the building.

Environmental Services Manager indicated (to the inspector):
- being aware that there were maintenance deficiencies within the home, but indicated that he was not aware of many of the above identified repairs, as such had not been communicated to him or the maintenance department by nursing and or housekeeping staff via the PM Works (electronic maintenance requisitions);
Environmental Services Manager indicated (to the inspector) that the day to day maintenance of the home (e.g. wall repairs, painting) was behind by approximately six weeks, as the maintenance workers were pulled from their daily job-schedules to work on another project in the home, therefore putting maintenance repairs behind;
- being aware of flooring replacement for three resident washrooms located in Pine (resident home area), but he was not aware of any other flooring being replaced or

repaired as of the time of this inspection.

Environmental Services Manager indicated it is an expectation that the home, furnishings and equipment are to be maintained in a safe condition and in a good state of repair, but such was difficult with the home being an older building.

The decision to issue an order is based on the widespread deficiencies in housekeeping and maintenance identified during the inspection. Furthermore there are potential infection control issues and risk of harm to residents related to specific identified issues. (554)

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

Jul 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 sions 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

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 sions de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416-327-7603

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

Issued on this 19 day of April 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CHANTAL LAFRENIERE - (A1)

Service Area Office /
Bureau régional de services : Ottawa

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 9, 2016	2016_328571_0011	01198-16	Complaint

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

PATRICIA MATA (571)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 25, 26, 27, 28, 29 and May 2, 3, 4, 2016

The following Complaint Logs were inspected:
008219-15 re: resident care; 002583-16 re: resident care; 000868-16 re: resident care; 011198-16 re: resident care; 002108-16 re: dining; and 002573-16 re: dining.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Director of Care, Resident Care Area Managers, Director of Quality, Infection Control Nurse, Registered Nursing Staff, Personal Support Workers, Dietary Manager, Dietary Staff, Program Staff, Pharmacist,residents and family members.

During the course of this inspection, the inspector: observed staff to resident interactions; observed resident to resident interactions; observed areas of the home including the kitchen and dining room; reviewed medical records; administrative records; and policies.

PLEASE NOTE: Two non-compliance's were found related to: security of drug supply [O. Reg. s. 130. 1]; administration of medication [O. Reg. s. 131. 1]. These non-compliance's were issued in Inspection #2016_360111_0009 which was conducted concurrently with this inspection and are contained in the Inspection and Order Reports of that inspection.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Food Quality
Medication
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Responsive Behaviours

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

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During the course of this inspection, ~~Non-Compliances were not issued.~~

0 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

Issued on this 9th day of May, 2016

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

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 24, 2016	2016_327570_0010	003109-16	Complaint

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 25- 29, May 02 & 03, 2016

Complaint intake number #003109-16 was inspected related to staff to resident alleged abuse. The following critical incidents intakes related to staff to resident alleged abuse were reviewed and inspected upon concurrently with this inspection: intake # 003109-16, 033355-15, 033880-15, 004180-16 and 011214-16.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Residents, Director of Quality (DOQ), Registered Nurses (RN), Resident Care Area Managers (RCAM), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Occupational Therapist (OT).

Also completed in the inspection: observation of staff to residents interactions;, observation of dining services, review of clinical health records of identified residents, relevant policies, licensee's internal investigations, staff educational records, and complaint logs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 6. (4) (b), by not ensuring that the staff and others involved in the different aspects of care for resident #002 collaborate with each other in the development and implementation of the plan of care, so that the different aspects of care are integrated and are consistent with and complement each other.

Related to Log #033880-15 for resident #002:

Review of clinical records for resident #002 indicated the resident is totally dependent on staff for toileting needs. According to Personal Support Workers and Registered Nursing Staff resident is incontinent but able to call for assistance if they want to have a bowel movement.

The home submitted Critical Incident Report (CIR) on a specified date for an incident involving resident #002. As per CIR, resident #002 rang the call bell and requested assistance from PSW #105 that they needed a bedpan for bowel movement. PSW #105 turned off the call bell and told the resident that it was meal time and they had to wait, and the assigned PSW #106 will be informed; PSW #105 walked away. When PSW #106 brought resident #002's meal tray, she/he found the resident emotionally upset and had been incontinent of bowel in bed; PSW #106 provided personal care and changed bed linens.

The plan of care for resident #002 in effect at time of incident directs the following:
- Toileting - Call bell to be within reach, and remind resident to use call bell to call staff; Total Dependence. Full staff performance of activity during entire shift.
- Bowel Continence - Incontinent - Had inadequate control of bowel - Use bedpan when in bed when requesting or having the urge.

Interview with RPN #113 and PSW #112 indicated to the inspector that whenever resident #002 requested a bedpan, it was provided right away and that PSW staff can ask registered staff to assist if a second PSW was not available.

Interview with the DOC and review of the licensee's internal investigation notes indicated that PSW #105 did not provide assistance to resident #002 as directed in the plan of care and did not report to other PSWs or registered staff that resident #002 had requested to be toileted, stating that she/he was busy with other residents and forgot to report to charge nurse. [s. 6. (4) (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 staff collaborate with each other in the development and implementation of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (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 failed to comply with LTCHA, 2007, s. 23. (2), by not ensuring that the results of the abuse or neglect investigation were reported to the Director.

Related to Log #033880-15 for resident #002:

Under O. Reg. 79/10, s. 104 (3), when making a report to the Director under subsection 23 (2) of the Act, if not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director (in 21 days unless otherwise specified by the Director).

The home submitted Critical Incident Report (CIR) under s. 24 Abuse/Neglect on a specified date for an incident involving resident #002.

Interview with the DOC indicated that resident #002 reported the incident to staff on a specified date for an incident that occurred on a specified previous shift . The incident was called in to the MOHLTC on same day when the incident was reported by the resident.

Review of the home's investigation notes indicated that the investigation was concluded on a specified date within three days after the incident was reported.

Review of Critical Incidents System and interview with the DOC confirmed that the Director was not notified of the results of the investigation. The CIR was later amended on a specified date, over four months following the incident, to include the results of the investigation. [s. 23. (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 the results of the abuse or neglect investigation were reported to the Director, to be implemented voluntarily.

WN #3: 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. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 104 (2), by not ensuring that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

Related to Log #011214-16 for resident #005

An incident involving resident #005 was called in to the MOHLTC on a specified date and time. The incident summary indicated that resident #005 reported to their spouse that they were physically abused; the resident could not describe the incident; the police was notified.

Interview with the DOC indicated the incident was reported to her. The DOC investigated the incident and spoke to the resident's spouse two days following the incident. The DOC confirmed the CIR was not submitted as required within 10 days as it was missed. The CIR was later submitted to the Director on a specified date over one month following the incident. [s. 104. (2)]

Issued on this 27th day of May, 2016

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

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

Ottawa Service Area Office
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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jun 08, 2016;	2016_360111_0009 (A3)	002607-16	Follow up

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

LYNDA BROWN (111) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

Please note

Amendment (3) completed to include a Directors Referral (DR) added to each Compliance Order and evidence under the Licensee Inspection Report was added to the Grounds for the Compliance Order #002 related to medications.
Thank you
Lynda Brown

Issued on this 16 day of June 2016 (A3)

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

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

LYNDA BROWN (111) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 25-29, 2016 & May 2-4, 2016.

The following inspections were completed concurrently: Follow-ups to CO #002 (log # 002607-16) related to care set out in plan provided to the resident; CO #003 (log # 002608-16) related to safe transferring of residents; CO # 004 (log # 002609-16) related to medications being administered to residents in accordance to the directions provided by the presciber; Other (log # 000857-16) related to lingering offensive odours; Complaint (log # 035494-15) related to allegations of abuse and complaints; Critical Incident Report (log # 036317-15) related to unexpected death.

In addition, a Compliant inspection was completed by Inspector #571 (log # 011198-16) related to multiple care concerns and medications. Additional information is identified under inspection # 2016_328571_0011.

During the course of the inspection, the inspector(s) spoke with residents, families, the Director of Care (DOC), Resident Care Area Managers (RCAM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), RAI Coordinators, Pharmacist, Program Assistant (PA), Maintenance, and Occupational Therapist (OT).

During the course of this inspection, observed/interviewed residents, observation of medication administration, medication rooms, a review of: Falls Prevention meeting minutes, medication incidents, staff training records,

complaints, and the home's investigations, a review of current and deceased resident health care records. There was also a review of the following home's policies- Falls Prevention and Management, and multiple Medication Administration policies.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Falls Prevention

Medication

Reporting and Complaints

Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **0 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
O.Reg 79/10 s. 36.	CO #003	2015_365194_0028	111
LTCHA, 2007 s. 6. (2)	CO #002	2015_365194_0028	111

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 :

(A2)
1. The licensee has failed to ensure that the "Falls Prevention and Management Program" policy was complied with.

Under O.Reg. 79/10, s.48 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:1.A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Re: Critical Incident Log # 036317-15 for resident #010:

Review of the home's policy "Falls Prevention and Management Program" (RESI-10-02-01) revised April 2013, indicated:
-the Interdisciplinary team: review the resident's falls risk assessment in order to establish an individualized care plan and communicate the care plan to all staff. Interventions must address the risk factors identified through the assessment process. Ensure that a Falls Prevention and Management Program is reviewed at the committee level.
-the registered staff: when a resident falls, complete a post fall assessment and update the care plan.

Review of the "Orchard Villa Fall Prevention and Management Committee Terms of Reference" (dated July 30, 2015) indicated the committee will identify high risk residents, analyze contributing factors to all falls, and propose interventions to minimize the risk of resident falls, injury, or transfer to acute care.

A critical incident report (CIR) was received by the Director on a specified date for an unexpected death. The CIR indicated on a specified date and time staff found resident #010 on the floor in room. The resident was transferred to hospital and returned from hospital the same day with injuries to specified areas. The resident's condition continued to deteriorate and the resident died four days later. The CIR indicated the resident was "deemed a high falls risk and had multiple previous falls".

Review of the care plan for resident #010 indicated the resident was at high risks for falls related to immobility, dementia, and responsive behaviours. The following interventions were in place at the time of the falls and included: check every hour for safety using Hourly Falls Checklist; place bed in lowest position possible; ensure falls mat is placed at bedside when in bed; ensure alarming device is

placed on mobility aid when up or in bed when returned to bed and staff to check alarming device every shift to ensure device is in place and working. Night shift to provide morning care, dress and bring to the nursing station every morning for close monitoring and seat near nursing station after meals, or when not in bed for close monitoring. The Falling Star Logo was not added to the resident's bed to indicate falls risk until after the fifth month.

Review of the progress notes for resident #010 during a six month period indicated the resident sustained a specified number of falls. 80% of the falls occurred from the resident's mobility aide and the last fall resulted in a serious injury to a specified area. Two of the interventions in place that were consistently used, were demonstrated as not effective as the resident continued to fall. The care plan did not indicate one of the interventions were use of Behaviour Supports Ontario (BSO).

Interview with RN #107(Falls Prevention Committee Lead) indicated the committee meets monthly to discuss falls statistics, provide staff training related to falls prevention, reviews and analyzes falls and provides strategies to prevent or reduce falls or injury. RN # 107 and the DOC indicated awareness of resident #010 having ongoing falls and stated "they were due to responsive behaviours". They both indicated the resident was a high risk for falls and was on the BSO program for responsive behaviours. The intervention indicated by staff as "followed by BSO" was not identified on the care plan. This intervention was discontinued after the second month of falls, despite the resident continuing to fall.

Interview of RPN #117 indicated all residents at high risk for falls are identified with a Falling Star logo at the head of the resident's bed, a list is also kept in front of the PSW's flow sheet binders and in front of nursing communication binders on each unit to indicate which residents are at high risk for falls. The RPN indicated further interventions would be identified on the resident care plan of interventions used to reduce falls/injury.

Interview with Occupational Therapist (OT) indicated completes "mobility equipment assessments" and "the seating and positioning includes residents who slide from wheelchairs". The OT indicated assessments are completed when "I get a referral sheet". The OT indicated the last mobility aide assessment completed for resident #010 was "approximately a year ago" when a referral was received for "sliding" in the mobility aide. The OT indicated "the issue was the cushion was not used properly inflated or lacking air". The OT indicated no other referrals were

received from nursing staff regarding this resident.

Review of the "Falls and Restraint Committee " meeting minutes indicated during the same six month period, only three meetings occurred. The minutes indicated the meetings were attended by RN's, RAI Coordinator, BSO lead, PT, Restorative care, and the Director of Quality Nursing (DQN). The meeting minutes indicated part of the meeting was to include a review of "fall statistics of the previous month by unit". There was no indication the fall statistics were analyzed for trends, especially when the monthly statistics demonstrated that two specified units had the highest number of falls each month. The minutes were also to include a review of "high risk residents" care plans by unit. Only one month's meetings (the fourth month) identified residents per unit as high risk for falls. Resident #010 was identified as a high risk of falls and indicated the trigger as a responsive behaviour. There was no indication of strategies to minimize the falls or risk of injury. The meeting also indicated “a trial of weekly falls meetings” was to occur for a six month period but there was no indication that this occurred.

A compliance order was issued as the severity was demonstrated in reviewing the progress notes for resident #010, during a six month period, the resident had sustained a specified number of falls. The last fall resulted in a serious injury and death. Eighty percent of the falls occurred from the resident's mobility aide due to "responsive behaviours". There was no indication that when the resident was being reassessed, and the care set out in the plan was not effective, different approaches were considered for resident #010 or that the interventions addressed the risk factors that were identified. Staff indicated the resident's falls were triggered by responsive behaviours, and was being monitored by BSO, despite the resident being discontinued from BSO after the second month and the resident continued to fall. Two interventions identified were demonstrated to not be effective in reducing the falls and there was no indication other interventions were considered. There was also no indication of referrals to other disciplines (i.e. PT or OT) was completed when 80% of the falls occurred from the resident's mobility aide. The scope was that although this was just one resident identified, the number of falls in the home (as demonstrated by the home's falls statistics and review of the Falls Prevention Committee Meeting minutes) indicated the committee had not reviewed the ongoing falls for resident #010, or any other residents identified as high risk residents, analyzed contributing factors to all falls, and proposed interventions to minimize the risk of resident falls, injury, or transfer to acute care, except for one of the months during the six month period. Review of the post fall assessments for resident #010 indicated only 3% of the falls had a post fall assessment completed.

In addition, non-compliance was identified for O.Reg. 79/10, s.8(1) related to Falls Prevention on June 8, 2015 during inspection #2015_293554_0009 and on November 15, 2016 during inspection # 2015_365194_0028.

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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that a drug was not administered to resident #006 unless it was prescribed.

Re: Complaint Log # 011198-16:

Resident #006 has lived in the home for a specified period of time. The resident receives off-site treatments specific to the resident's diagnosis. On a specified

date, the physician ordered a specified medication, at specified times, to correct abnormalities with the resident's metabolism specific to the resident's diagnosis.

A review of a complaint letter submitted to the home by the residents family member, approximately one month later, indicated that the off-site treatment facility was provided a current medication list for resident #006 at the resident most previous treatment. The staff at the treatment facility became aware that resident #006 was receiving this specified medication and notified the home to have this medication discontinued, due to side effects. As a result, the medication was ordered discontinued on the same day by the physician.

A review of the medical record indicated that on a specified date (the day the physician ordered the medication discontinued) the order to discontinue the drug was verified by two nurses. Review of the electronic medication administration record (eMAR) indicated the medication had not been discontinued and was administered by RPN #122 the following day after it was discontinued.

A review of a medication incident form, indicated four days later, RPN #123 had a near miss of almost administering the drug to resident #006 as medication was still on the eMAR.

In an interview, the Director of Care (DOC) indicated on a specified date, RPN #123 attempted to administer the drug to resident #006 as the order remained on the eMAR but the resident had informed RPN #123 the medication was discontinued and therefore the medication was not administered. The DOC indicated that the second nurse who verified the physician order should have ensured it was no longer on the eMAR.

A Compliance Order (CO #004) under O.Reg.79/10, s. 131(1) was issued on January 15, 2016 and then amended on April 19, 2016 with a compliance date of February 29, 2016. [s. 131. (1)]

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

Related to log # 002609-16 for resident #013:

Review of the medication incident reports indicated on a specified date, a call was received by pharmacy for resident #013, indicating an incorrect dosage calculation

had been indicated on the eMAR (and the medication label) for an electrolyte supplement. The resident was receiving a 56 % increased dose of the medication for approximately five months.

Review of the health care record for resident #013 indicated the resident was admitted on a specified date and has multiple diagnoses which included a cardiac condition. Approximately one month after admission, the physician ordered the electrolyte supplement at a specified dose. The pharmacy sent the medication but the directions had an incorrect calculation for the liquid on the bottle (more than the dose that was ordered).

Review of the progress notes for resident #013 indicated on the day the medication incident was discovered by pharmacy, the physician assessed the resident and ordered electrolyte blood work. Review of the blood work completed seven days later indicated the electrolyte was within therapeutic levels.

Therefore the resident received 56% increased dose of the specified medication for a period of approximately five months when the medication incident was discovered by pharmacy. [s. 131. (2)]

3. Related to log # 002609-16 for resident #014:

Review of Medication Incident report for resident #014 indicated on a specified date, the resident had been receiving a sleeping aide medication in the morning for three days that was to be administered at bedtime.The nurse contacted the physician and the pharmacy on the third day and had the administration time changed to bedtime.

Review of the health record for resident #014 indicated the resident was admitted three days prior to the medication incident. The progress notes indicated on the day the resident was admitted, the (BSO) staff member completed the admission assessment and indicated the resident was to receive the sleeping aide medication to assist the resident with responsive behaviours and sleep. Three days later, in the evening, the resident's SDM was visiting and staff noted the resident had not "slept for two days" and was demonstrating responsive behaviours. The SDM inquired whether the resident had been receiving the sleeping aide at bedtime and the nurse determined at that time the medication had not been given at the correct administration time. The nurse then contacted the physician to have the administration time changed to the correct time.

Therefore, the resident was admitted with a sleeping aide medication, staff documented awareness on admission that the medication was to be administered at bedtime for sleep and the medication was administered in the morning for a three day period until the medication incident was discovered by the resident's SDM.

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 002

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that when the resident had fallen, the resident had been assessed post fall, using a clinically appropriate assessment instrument that is specifically designed for falls.

Re: Critical Incident Log # 036317-15 for resident #010:

Review of the progress notes for resident #010 indicated during a six month period the resident sustained a specified number of falls. Review of the post fall assessments for resident #010 during the same time period indicated only 36 % of the falls had a post fall assessment were completed.

WN #4: 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 :

(A1)
1. The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.

On a specified date and time, on a specified unit, Inspector #571 observed Program Assistant (PA) #124 request that RPN #122 unlock the medication room door. The RPN #122 unlocked the door and left it open and returned to the medication cart in the hallway to administer medications. The medication room was observed to contain the following: two unlocked cupboards with medications including, Lactulose liquid; Tylenol pills and liquid; eye drops; Gravol and an unlocked box of discarded medication. In addition, a treatment cart was also unlocked in the medication room and contained medicated ointments. There was also a fridge in the medication room that was also unlocked and contained insulin and eye drops.

In an interview, RPN #122 indicated the RPN "opens" the medication room door for program staff and restorative staff as the resident's charts are kept in the room and the staff need to access the charts and does not remain in the room with them.

In an interview with PA #124, indicated that the medication room door is unlocked and left open by registered nursing staff when requested to access the resident's charts.

In an interview, the DOC indicated that the RPN should remain in the medication room with unregistered staff unless all medication is locked up.

Therefore, the licensee failed to ensure that the area where drugs were stored in the medication room on Cedar unit were kept locked at all times(571).

Issued on this 16 day of June 2016 (A3)

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : LYNDA BROWN (111) - (A3)

Inspection No. / No de l'inspection : 2016_360111_0009 (A3)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 002607-16 (A3)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Jun 08, 2016;(A3)

Licensee / Titulaire de permis : CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD : Orchard Villa
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Trish Talabis

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To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, 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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

(A1)
The licensee shall prepare, implement, and submit a corrective action plan to provide the following, and to also identify who is responsible for each action, and the completion date:
1.All residents currently in the home at moderate to high risk for falls will be reassessed, and interventions that have been considered and determined to not be effective, will have their plan of care reviewed and revised, to ensure other interventions are considered, where possible.
2. The Registered Nursing staff will review the home s Falls Prevention and Management policy to ensure they are aware of their responsibilities, specifically related to post fall assessments, reporting requirements to physicians, and review of care plans to ensure other interventions are considered when the interventions used to prevent falls and or injury have been demonstrated as ineffective,
3. The Falls Prevention and Management committee will review the "Orchard Villa Fall Prevention and Management Committee Terms of Reference" to ensure awareness of roles and responsibilities, specifically related to analyzing contributing factors to all falls, and proposing interventions to minimize the risk of resident falls and or injury; Establish a process to monitor compliance to established policies and procedures, especially when new interventions are being tried,
4. Develop and implement a monitoring process to ensure all current residents identified as moderate to high risk for falls, have been reassessed, and other interventions have been considered when interventions used have been determined to be ineffective.

This plan is to be submitted by May 26, 2016 to Lynda Brown, LTC Inspector, via email to OttawaSAO.MOH@ontario.ca

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that the "Falls Prevention and Management Program" policy was complied with.

Under O.Reg. 79 10, s.48 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:1.A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Re: Critical Incident Log # 036317-15 for resident #010:

Review of the home s policy "Falls Prevention and Management Program" (RESI-10-02-01) revised April 2013, indicated:
-the Interdisciplinary team: review the resident s falls risk assessment in order to establish an individualized care plan and communicate the care plan to all staff. Interventions must address the risk factors identified through the assessment process. Ensure that a Falls Prevention and Management Program is reviewed at the committee level.
-the registered staff: when a resident falls, complete a post fall assessment and update the care plan.

Review of the "Orchard Villa Fall Prevention and Management Committee Terms of Reference" (dated July 30, 2015) indicated the committee will identify high risk residents, analyze contributing factors to all falls, and propose interventions to minimize the risk of resident falls, injury, or transfer to acute care.

A critical incident report (CIR# 2693-9999966-15) was received by the Director on December 29, 2015 for an unexpected death. The CIR indicated on December 25, 2015 at 06:15, staff found resident #010 on the floor in room. The resident was transferred to hospital and returned from hospital the same day with a fractured nose, swelling to bilateral eyes, bruise to arm, skin tear to one finger and sutures to her forehead. The following day, the resident "was not doing well", POA and MD were contacted and decision made to keep resident in the home. The resident died on December 29, 2015. The coroner indicated the cause of death was due to "blunt force trauma to the face, related to her previous fall". The CIR indicated the resident was "deemed a high falls risk and had multiple previous falls".

Review of the care plan for resident #010 indicated the resident was at high risks for falls related to immobility, dementia, responsive behaviours (will put herself on the floor usually after family visits). The following interventions were in place at the time of the falls and included:
-check every hour for safety using Hourly Falls Checklist,
-place bed in lowest position possible; ensure falls mat is placed at bedside when in bed,
-ensure sensor pad alarm is placed on wheelchair (when in wheelchair) or on her bed when in bed; check at start of shift to ensure sensor pad alarm is in place and is

working; has removed wheelchair alarm by removing clothing-staff to ensure alarm is working and attached to resident, if removed, staff to apply immediately;
-night shift to provide morning care, dress and bring to the nursing station every morning for close monitoring & seat near nursing station after meals or when not in bed for close monitoring,
-on November 13, 2015, the Falling Star Logo was added above the resident's bed to indicate falls risk.

Review of the progress notes for resident #010 during a six month period (from June 27, 2015 to December 29, 2015) indicated the resident sustained 25 falls. Twenty of the falls occurred when the resident slid out of her wheelchair and the last fall resulted in a head injury:
-on June 27, 2015 at 22:53 the "resident slid from w c 2x this shift. The first time alarm was sounding in the dining room after dinner". The resident was transferred back to wheelchair and brought to the nurse's station. Staff then went to get a co-resident out of the dining room and when staff returned to the nurse's station, the resident "was found sitting on the floor again leaning against her w c with alarm sounding". No injuries or pain noted.
-on July 5, 2015 at 17:40, the resident was found sitting on the foot rest of by the nursing station. The resident had just returned from the dining room. At the time of the fall there were no injuries but a PSW later reported bruising noted to the resident's right arm.
-on July 9, 2015 at 22:45, the resident was found sitting on the floor at the end of her bed. No injuries noted.
-on July 16, 2015 at 17:35, the resident was found sliding out of wheelchair onto the footrest in the dining room.No injury noted.
-on July 19, 2015 at 14:39, staff noted resident attempting to "get out of her chair, after her visitors left". Resident was placed at the nursing station to monitor.
-on July 23, 2015 the BSO Noted "Resident is currently in the BSO program and is been monitored on a monthly basis. Resident s follow-up was completed today and it was document that resident is still having responsive behaviors after family visits. Resident continues to put herself on the floor". Resident is now on a sleep wake study starting night of the July 23-July 26. MD to assess sleep weak study and BSO will reassess resident s interventions. The resident was discontinued from the BSO program on July 26, 2015.
-on July 25, 2015 at 10:20, a co-resident called staff to report the resident was sitting on buttocks on floor. No pain or injury was noted.
-on August 1, 2015 at 14:42, the resident "was noted slipping self out of wheel chair".

No injuries noted.
-on August 4, 2015 at 10:20, a PSW "found resident sitting on the footrests of her w c in front of the nurse s station". The chair alarm was still attached to the wheelchair and resident but did not activate. No injury or pain was noted.
-on September 8, 2015 at 14:39 staff documented a "Late Entry for Sept 7, 2015" indicating the "resident was put to bed but refused to stay in bed continued to get out repeatedly, resident was anxious and aggressive after relatives visited, left bed in low position. The call bell was observed attached but not sounding after getting out of bed as PSW observed resident lying prone on fall mat in front of bed".
-on September 11, 2015 at 21:00, PSW reported the resident was on the floor. The resident was found "kneeling on the floor, in front of her W C". No pain or injury noted. The resident was transferred to wheelchair and "is currently sitting at nurse s station for close monitoring".
-on September 22, 2015 at 22:50, the resident's "alarm was noted to be sounding at, upon checking resident was noted sitting at the edge of bed trying to get up". The resident was found with "2 skin tear to her left forearm".
-on September 27, 2015 at 16:30, the resident "had a witnessed fall by the nursing station. The resident slid out of her wheelchair". The resident had visited with son prior and was upset when son left. No injury noted. The staff indicated "chair alarm on resident but did not sound".
-on October 3, 2015 at 12:40, PSW reported the resident was on the floor in the dining room, the fall was un-witnessed. PSW reported "I heard the alarm ringing". No injury noted.
-on October 12, 2015 at 10:45, BSO staff noted "was on unit doing rounds and noted resident was very agitated and aggressive towards staff". The resident "was also attempting to put herself on the floor while yelling "I am going to throw myself on the floor and crack my skull open". The "resident would move her body to the edge of her wheelchair, staff would assisted her back into her wheelchair so resident would not have a fall and resident would continue to place herself back to the edge of her chair while striking out at staff. BSO and charge nurse monitored the resident for 1hr and 45mins until the resident was calm.
-on October 25, 2015 at 23:00, the resident was received with "increased agitation sitting in wheel chair in front of nursing station screaming out loud and attempted to slide down from wheel chair several times". At 23:15 resident did slide down from wheel chair and sat on the floor when staff while staff were attending another resident. No injury noted. 1: 1 intervention x 15 minutes and reassurances to calm resident down with good effect.
-on October 29, 2015 at 22:11, resident was in wheelchair after dinner, sitting across

from nursing station, was shouting and tearful, "once resident get into that mood she is noted to be constantly sliding herself" out of wheelchair. The resident was then witnessed falling out wheelchair by charge nurse, who was sitting at the desk. No injury noted.
-on November 1, 2015 at 15:45, PSW reported the "resident was on the floor". Resident was found sitting on foot rest of wheelchair, alarm attached to her shirt but not separated". Resident "supposedly slid herself from the wheelchair".
-on November 16, 2015 at 15:00, resident was in TV lounge participating in activity with program staff and once program was finished and everyone was dispersed, the resident became agitated and slid from her wheelchair. No injuries were noted.
-on November 21, 2015 the BSO indicated resident now palliative, "when relatives come to visit her, when they leave, she will throw herself from the wheelchair or climb out of bed onto the floor resulting into falls and skin tear".
-on December 2, 2015 physician assessed the resident and ordered "vitals only once if resident has fallen, resident is palliative".
-on December 5, 2015 at 18:40, the resident was witnessed sliding out of her wheelchair. No injuries were noted.
-on December 12, 2015 at 15:20, the resident was witnessed sliding off her wheelchair. No injuries noted. At 19:15 the resident was found on the floor and staff indicated "resident has HX of being upset and agitated post family visit and will deliberately slide herself from W C".
-on December 18, 2015 at 14:08, the resident slid from her wheelchair onto her buttocks and no injury noted. The resident was placed at nursing station desk to monitor. At 15:45, while seating at the nursing station, the resident slid down out of her wheelchair and was sitting on footrests. No injuries noted.
-on December 22, 2015 at 17:10, the resident was agitated and "noted to be shouting, and trying to slide off her chair, staff kept trying to redirect with some success". While in the dining room, the resident "had slide herself from chair and onto the floor". Staff indicated "she will hurt herself if she continues to slide herself to the floor". No injury noted.
-on December 24, 2015 at 20:00, the resident was found on the floor at bedside. "Before incident resident was lying in bed. Her call bell did not ring". The resident sustained a bruise to the nose. The resident was placed in wheelchair and taken to the nursing station.
-on December 25, 2015 the resident had remained awake most of the night and at 05:30 the resident was transferred to bed. At 0615 the alarm was heard "sounding" and the resident was found on the floor at bedside (CIR# 2693-9999966-15).

Interview of RN #107(Falls Prevention Committee Lead) indicated the committee meets monthly to discuss falls statistics, provide staff training related to falls prevention, reviews and analyzes falls and provides strategies to prevent or reduce falls or injury. RN # 107 and the DOC indicated awareness of resident #010 having ongoing falls and stated "they were due to responsive behaviours" as the resident would "throw herself to the floor from her wheelchair after the family had visited". They both indicated the resident was a high risk for falls and was on the BSO program for her responsive behaviours.

Interview of RPN #117 indicated all residents at high risk for falls are identified with a Falling Star logo at the head of the resident's bed, a list is also kept in front of the PSW s flow sheet binders and in front of nursing communication binders on each unit to indicate which residents are at high risk for falls. The RPN indicated further interventions would be identified on the resident care plan of interventions used to reduce falls injury.

Interview of OT indicated he completes "mobility equipment assessments" and "the seating and positioning includes residents who slide from wheelchairs". The OT indicated assessments are completed when "I get a referral sheet". The OT indicated "there is blank referral sheets on each unit for physio and OT" for nursing to complete. The OT indicated the last wheelchair assessment was completed for resident #010 approximately a year ago when received a referral that resident was sliding in wheelchair. The OT indicated "the issue was the cushion was not used properly or lacking air". The OT indicated no other referrals were received from nursing staff regarding the resident sliding from wheelchair.

Review of the "Falls and Restraint Committee " meeting minutes indicated the meetings occurred on October21, December 2 & 16, 2015, January 20 & March 20, 2016. The minutes indicated meetings were attended by RN s, RAI Coordinator, BSO lead, PT, Restorative care, and the Director of Quality Nursing (DQN). The meeting minutes indicated part of the meeting was to include a review of "fall statistics of the previous month by unit". There was no indication the fall statistics were analyzed for trends, especially when the monthly statistics demonstrated that two units (Birch and Pine) consistently had the highest number of falls each month. The minutes were also to include a review of "high risk residents" care plans by unit. The October 21, 2015 was the only meeting that identified one resident per unit as high risk for falls residents. Resident #010 was identified as high risk of falls and indicated the resident "often reacts to when her family leaves the building and will put

herself on the floor". There was no indication of strategies to minimize the falls or risk of injury. The meeting also indicated “a trial of weekly falls meetings” was to occur until March 2016, but there was no indication that this occurred.

There was no indication that when the resident was being reassessed, and the care set out in the plan was not effective, different approaches were considered for resident #010 or that the interventions addressed the risk factors that were identified. Staff indicated the resident s falls were triggered by responsive behaviours, and was being monitored by BSO, despite the resident being discontinued from BSO on July 26, 2015 and the resident continued to fall. The interventions of “placing the resident in front of the nursing station for close monitoring” or the use of "a chair and or bed alarm" were not effective in reducing the falls and no indication other interventions were considered. There was also no indication of referrals to other disciplines (i.e. PT or OT) was completed when 20 out of the 25 falls occurred from the resident falling out of her wheelchair.

A compliance order was issued as the severity was demonstrated in reviewing the progress notes for resident #010, during a six month period (from June 27, 2015 to December 29, 2015), the resident had sustained 25 falls. The last fall resulted in a head injury and death. Twenty out of the 25 falls occurred when the resident slid out of her wheelchair due to responsive behaviours and there was no indication that when the resident was being reassessed, and the care set out in the plan was not effective (placing the resident in front of the nursing station or the use of a chair and or bed alarm), that other interventions were considered. There was no indication of referrals to other disciplines (i.e. PT or OT) when 20 out of the 25 falls occurred from the resident falling out of her wheelchair. The scope was that although this was just one resident identified, the number of falls in the home (as demonstrated by the home s falls statistics and review of the Falls Prevention Committee Meeting minutes) indicated the committee had not reviewed the ongoing falls for resident #010, or any other residents to identify high risk residents, analyzed contributing factors to all falls, and proposed interventions to minimize the risk of resident falls, injury, or transfer to acute care, except for the month of October 2015. Review of the post fall assessments indicated only 9 out of the 25 falls had a post fall assessment completed. In addition, non-compliance was identified for O.Reg. 79 10, s.8(1) related to Falls Prevention on June 8, 2015 during inspection #2015_293554_0009 and on November 15, 2016 during inspection # 2015_365194_0028. (111)

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

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

Jun 30, 2016

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2015_365194_0028, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Order / Ordre :

The licensee shall prepare, implement and submit a corrective action plan to ensure the following, and to include who is responsible for each action and the completion date:
1. develop and implement a monitoring process to ensure that all medications are administered to all residents in accordance with the direction for use, and as specified by the prescriber; and to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident,
2. identify actions to be taken when non-compliance is identified with same,

The plan is to be submitted by May 26, 2016 via email to Lynda Brown, LTC Inspector, at OttawaSAO.MOH@ontario.ca.

Grounds / Motifs :

(A2)
1. A Directors Referral was also issued for the Compliance Order.

The licensee has failed to ensure that a drug was not administered to resident #006 unless it was prescribed.

Re: Complaint Log # 011198-16:

Resident #006 has lived in the home for a specified period of time. The resident receives off-site treatments specific to the resident's diagnosis. On a specified date, the physician ordered a specified medication, at specified times, to correct abnormalities with the resident's metabolism specific to the resident's diagnosis.

A review of a complaint letter submitted to the home by the residents family member, approximately one month later, indicated that the off-site treatment facility was provided a current medication list for resident #006 at the resident most previous treatment. The staff at the treatment facility became aware that resident #006 was receiving this specified medication and notified the home to have this medication discontinued, due to side effects. As a result, the medication was ordered discontinued on the same day by the physician.

A review of the medical record indicated that on a specified date (the day the physician ordered the medication discontinued) the order to discontinue the drug was verified by two nurses. Review of the electronic medication administration record (eMAR) indicated the medication had not been discontinued and was administered by RPN #122 the following day after it was discontinued.

A review of a medication incident form, indicated four days later, RPN #123 had a near miss of almost administering the drug to resident #006 as medication was still on the eMAR.

In an interview, the Director of Care (DOC) indicated on a specified date, RPN #123 attempted to administer the drug to resident #006 as the order remained on the eMAR but the resident had informed RPN #123 the medication was discontinued and therefore the medication was not administered. The DOC indicated that the second nurse who verified the physician order should have ensured it was no longer on the

eMAR.

A Compliance Order (CO #004) under O.Reg.79/10, s. 131(1) was issued on January 15, 2016 and then amended on April 19, 2016 with a compliance date of February 29, 2016. [s. 131. (1)]

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

Related to log # 002609-16 for resident #013:

Review of the medication incident reports indicated on a specified date, a call was received by pharmacy for resident #013, indicating an incorrect dosage calculation had been indicated on the eMAR (and the medication label) for an electrolyte supplement. The resident was receiving a 56 % increased dose of the medication for approximately five months.

Review of the health care record for resident #013 indicated the resident was admitted on a specified date and has multiple diagnoses which included a cardiac condition. Approximately one month after admission, the physician ordered the electrolyte supplement at a specified dose. The pharmacy sent the medication but the directions had an incorrect calculation for the liquid on the bottle (more than the dose that was ordered).

Review of the progress notes for resident #013 indicated on the day the medication incident was discovered by pharmacy, the physician assessed the resident and ordered electrolyte blood work. Review of the blood work completed seven days later indicated the electrolyte was within therapeutic levels.

Therefore the resident received 56% increased dose of the specified medication for a period of approximately five months when the medication incident was discovered by pharmacy. [s. 131. (2)]

3. Related to log # 002609-16 for resident #014:

Review of Medication Incident report for resident #014 indicated on a specified date, the resident had been receiving a sleeping aide medication in the morning for three days that was to be administered at bedtime. The nurse contacted the physician and

the pharmacy on the third day and had the administration time changed to bedtime.

Review of the health record for resident #014 indicated the resident was admitted three days prior to the medication incident. The progress notes indicated on the day the resident was admitted, the (BSO) staff member completed the admission assessment and indicated the resident was to receive the sleeping aide medication to assist the resident with responsive behaviours and sleep. Three days later, in the evening, the resident's SDM was visiting and staff noted the resident had not "slept for two days" and was demonstrating responsive behaviours. The SDM inquired whether the resident had been receiving the sleeping aide at bedtime and the nurse determined at that time the medication had not been given at the correct administration time. The nurse then contacted the physician to have the administration time changed to the correct time.

Therefore, the resident was admitted with a sleeping aide medication, staff documented awareness on admission that the medication was to be administered at bedtime for sleep and the medication was administered in the morning for a three day period until the medication incident was discovered by the resident's SDM. (111)

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

May 26, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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

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

Issued on this 16 day of June 2016 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN - (A3)

Service Area Office /
Bureau régional de services : Ottawa

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 8, 2016	2016_327570_0014	008633-16	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

SAMI JAROUR (570), AMBER LAM (541), CATHI KERR (641), DENISE BROWN (626), LYNDA BROWN (111), MARIA FRANCIS-ALLEN (552), PATRICIA MATA (571)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 5 - 8, 11 - 15, 18, 2016

The following intakes were reviewed and inspected upon concurrently during this inspection:

Follow-up Logs:

- 002604-16 - related to CO#001 - Duty to protect s. 19(1) compliance date April 30, 2016 issued under inspection # 2015_365194_0028.
- 014267-16 – related to CO #002- O.Reg.79/10, s.131(1) & (2) medications administered that were discontinued and not administering medications as ordered due date May 26, 2016 issued under inspection # 2016_360111_0009
- 014268-16 – related to CO #001- O.Reg. 79/10, s.8(1)(b) Falls Prevention and Management policy was not followed with due date June 30, 2016 issued under inspection # 2016_360111_0009

Critical incidence Logs:
- 003951-16, 012213-16, 013375-16, 014899-16, 014998-16, 016061-16, 016655-16 - specific to staff to resident alleged abuse/neglect.
- 019833-16, 019884-16, 019887-16, 019889-16, 020497-16, 020874-16, 020882-16 - specific to staff to resident alleged neglect of a resident in relation to falls and falls risk management .
- 009725-14, 014533-16 and 011764-16 - specific to a fall with injury, resulting in change in resident's condition;
- 014122-16 - specific to an injury during self-transferring.
- 013742-16 - specific to improper care.
- 019309-16 - specific to missing resident.
- 020155-16 - specific to medication error.
- 020052-16 - specific to missing money.

Complaints Logs:
- 013653-16, 016653-16, 017964-16 - specific to residents care issues.
- 013668-16 - specific to staff to resident abuse/neglect
- 018031-16 - specific to staffing issues.
- 019532-16 - specific to discharge of a resident.
-020075-16 - specific to responding to complaints and care issues.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Residents, Families, Registered Nurses (RN), Resident Care Area Managers (RCAM), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nurse Administrative Assistant, Dietary Manager, Dietitian, Programs Manager, Housekeeping staff, Occupational Therapist (OT), Physiotherapist (PT), and Dietary Aide.

During the course of this inspection, the inspector(s) toured the home, observed

dining services, medication administration practices, infection control practices and staff to resident interactions and provision of care; reviewed clinical health records of identified residents, relevant policies, licensee's internal investigations, staff educational records, relevant program evaluations, complaints log, Residents and Family Councils minutes.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2015_365194_0028	571
O.Reg 79/10 s. 8. (1)	CO #001	2016_360111_0009	111

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on the resident's preferences.

Related to Log #013653-16 for resident #026:

Review of clinical health records indicated the resident is cognitively intact and able to make own decisions. The resident requires no assistance with meals and has no evidence of swallowing difficulties or other ailments associated with eating.

Review of the plan of care related to eating directs the staff as followed:
- resident is to sit up on the side of the bed for all meals. Is capable of sitting on the edge of bed to eat and take medications
- staff must insist that the resident sits up
- all staff to be aware that resident will tell new staff or infrequent staff that the resident does not get up on the side of bed for meals
- PSW to report to charge nurse any refusal to sit up.

Documentation found in multidisciplinary progress notes dated indicated the following "resident sits up for meals. Knows they have to otherwise - no meal"

Review of the food and fluid flow sheet completed by staff indicated the resident did not receive the following meals during a six week period in 2016: Breakfast - six meals; lunch four meals; dinner three meals.

During an interview with the resident on July 11, 2016 at noon - found the resident lying in bed. The resident explained it is his/her preference to have meals sitting in bed with head of bed elevated but there is some staff that refuse and tell the resident to get up and go to the dining room. The resident did not identify who the staff members were. The resident explained being in bed for most of the day as it is painful to weight bear. The resident indicated PSW #122 did not bring a breakfast tray “this morning” and allegedly told the resident he/she should "have gotten up". The resident indicated on a weekly basis that he/she may miss meals 3 times for the week because a meal tray is not brought to the room. The resident indicated it was not any particular meal that was missed - could be breakfast, lunch or dinner.

During interviews on July 11 and 12, 2016 with PSWs #122, 124, 125 and RPNs #104 and 120 all indicated they have been told the resident should not be given medications or meals in bed until sitting up in bed with both feet hanging at the side of the bed. The staff members indicated they have never refused to give meals to the residents. They indicated at times the resident has become frustrated with their request to have the resident sit up in the bed and will tell them to "keep the food". The PSWs indicated if the resident misses any meals, the resident receives snacks from the nourishment cart.

During an interview with DOC on July 14, 2016 she confirmed the resident was able to make own decisions. The DOC acknowledged it is within the resident's right to make the decision surrounding positioning during meals.

Therefore the home has failed to ensure the plan of care is based on the resident's preferences. [s. 6. (2)]

2. The licensee failed to ensure the plan of care was provided to residents #002, 057, 058 and 062 as specified in the plan related to falls prevention and management.

Related to Log #019833-16 for resident #002:

A critical incident report was received by the Director on an identified date in 2016 for a fall incident involving resident #002. The CIR indicated the resident #002 sustained a fall from wheelchair near the nursing station as the resident was to have a personal alarm in place and the alarm was not activated as it was not turned on. The resident was a high risk for falls. No injury was sustained as a result of the fall.

Review of the progress note for resident #002 following the fall indicated the staff heard the resident's attachment to the wheelchair falling on the floor. The resident then reached for the bar and then slipped to the floor from the wheelchair. No injuries noted. The seat belt alarm was not reset and PSW re-educated re: important to reset the seat belt alarm. Post fall huddle done. Fall factor checklist, Scott Falls assessment and post fall investigation completed. Fall tracking sheet updated and care plan updated.

Review of the current plan of care for resident #002 indicated under safety devices/restraints that attachment to wheelchair is used when up in wheelchair as PASD for maintaining position. Interventions included resident has tendency to remove safety devices including alarming device. Ensure that alarming device is initiated when in wheelchair/bed. Under falls/balance, high risk for falls, sustained falls on eleven identified dates. Interventions include: check every hour, falls prevention interventions in place: safety devices including alarming device, resident removes safety devices and staff to ensure that all are in place and reapply if removed.

Therefore, resident #002's plan of care was not followed when sustained a fall on an identified date as alarming device was applied but not activated to alert staff.

Related to Log # 019889-16 for resident #057:

A critical incident report was received by the Director on an identified date of 2016 for an allegation of neglect that occurred on same date. The CIR indicated resident #057 is high risk for falls and was found with personal alarming device that "may not have been turned on". The resident did not sustain a fall. The CIR indicated the staff had been re-instructed to assess at beginning of shift all residents at high risk for falls to ensure personal safety device is in place and working.

Review of the current plan of care for resident #057 indicated the resident is a high risk for falls related to weakness and high Scott's falls risk assessment score. Under Safety Devices/Restraints due to attempting to self transfer. Interventions included: alarming devices in place at all times; Keep door open to ensure staff hear alarm; Staff to check

alarms every shift that they are turned on and functioning properly; resident will unclip personal alarm and self transfer to the bathroom-staff to make sure to put clip alarm at the back- away from resident's reach.

The resident was not provided care as specified in the plan related to safety devices when the alarming device was applied but not turned on to alert staff.

Related to Log #019887-16 for resident #058:

A critical incident report was received by the Director on an identified date in 2016 for an allegation of staff to resident neglect that occurred earlier on same day. The CIR indicated resident #058 is at high risk for falls and was to wear a personal alarming device. The resident was found with personal alarm device not turned on. The resident did not sustain a fall.

Review of the current plan of care for resident #058 indicated the resident was a high risk for falls related to history of falls on seven identified dates during a four months period in 2016 and Scott's fall risk screen. Under safety devices/restraints related to falls risk. Interventions included: has a floor mat down when in bed, mat should be taken up and put out of the way when up; to wear a personal alarm when in chair or bed. Staff to respond to alarm and make sure that resident #058 always gets assistance while using toilet.

On an identified date, the resident was not provided care as set out in the plan of care related to safety devices when the personal alarm device was not turned on.

Related to Log # 019884-16 for resident #062:

A critical incident report was submitted to the Director on an identified date in 2016 for an allegation of staff to resident neglect that occurred earlier same day. The CIR indicated that resident #062 sustained a fall with no injury and determined a staff member failed to ensure resident #062 personal alarming device was turned on. The resident was a high risk for falls.

Review of the current plan of care for resident #062 indicated the resident was a high risk for falls related to identified multiple diagnosis, history of falls, and Scott's fall risk screen. Interventions included alarming device and staff to ensure the device is on at all times, check that all alarms are working and activated. (111)

On an identified date, resident #062 was not provided care as set out in the plan of care related to safety devices when the personal alarming device was not turned on.

Related to Log # 020497-16 for resident #062:

Critical Incident Report was submitted to the Director on an identified date in 2016 due to an alleged neglect of resident #062 specific to the resident's personal alarm not turned on when staff saw the resident walking out from room with the alarm not ringing. The resident did not sustain a fall related to this incident.

Review of clinical records for resident #062 indicated the resident had multiple diagnoses that include cognition impairment; the resident had been identified as a high risk for falls related to history of falling and other impairments. The resident was readmitted to the home following recent hospitalization on an identified date in 2016 and since then the resident had gotten frail and weak.

On July 14, 2016 interview with PSW #144 indicated to Inspector #641 that resident #062 was at high risk for falls and that alarming devices were in place, a fall's mat on the floor, and staff were to put the bed in the lowest position when the resident was in bed.

On July 18, 2016 at 1035 hours interview with RPN #158 indicated to inspector #626 that resident #062 used a personal alarm when in bed and chair to alert staff for falls prevention.

On July 18, 2016 interview with PSW #144 indicated to inspector #626 that resident #062 had a chair alarm due to risk of falling. The PSW indicated the alarm is checked every hour.

The alarming device was not turned on as directed in the plan of care for resident #062 on an identified date when the resident was noticed by staff walking without the alarm ringing to alert staff.

The resident was not provided care as specified in the plan of care related to safety devices when resident #062's alarming device was not turned on to alert staff on two identified dates.

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

provided to the resident as specified in the plan, related to nutrition and hydration.

Related to Log #017964-16 for resident #046:

A complaint was made by the resident's substitute decision maker (SDM) on an identified date in 2016. The SDM indicated the resident is at risk of choking on liquids due to a medical condition and all liquids must be thickened. The SDM indicated on an identified date at one meal time, water without a thickening agent was offered to the resident. On an identified date, the complainant went in to visit at 1120 hours and found the resident with a glass of water without a thickening agent. The complainant took the water to the nurse and the nurse said the complainant was correct and the water should have been thickened.

The home also submitted a Critical Incident Report (CIR) to the Director on an identified date indicating that a written complaint was received by the resident's SDM about the same incident described above.

Review of the licensee's investigation concluded that the resident was offered liquids with no thickening agent.

Review of the resident's care plan and other clinical health documentation all indicated the resident was on honey thick fluids and should not be offered fluids with a straw due to swallowing concerns.

Interview with PSW #146 explained the resident required thickened fluids and was also on boost. The resident was total assistance for eating. Staff member was not aware or does not recall hearing that the resident was ever given fluids without a thickening agent. Information regarding dietary requirements can be found in the kardex, staff dining room and nourishment cart. This information was confirmed by RPN #104, #120 and PSW #126.

Therefore, resident #046’s plan of care was not followed when staff did not provide thickened fluids to the resident as identified in the plan of care. [s. 6. (7)]

4. The licensee failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring the care set out in the plan of care was provided to resident #048 as specified in the plan, related to bathing and falls prevention.

Related to Log #013742-16 for resident #048:

Critical Incident Report (CIR) indicated on an identified date in 2016, personal support worker (PSW) #131 was assisting resident #048 with shower when the shower chair tipped over with the resident still in it. The resident sustained an injury to a body part.

Review of clinical records for resident #048 indicated was admitted with multiple diagnosis including cognitive impairment.

Review of clinical records and interviews on July 11 and 14, 2016 with PSWs #124,131 and 145 indicated resident #048 is totally dependent in activities of daily living.

Review of resident #048's plan of care in effect at time of the incident indicated the resident was at moderate risk for falls. The plan of care indicated the following interventions under bathing and shampooing:
- Total dependence. Full staff performance of activity during entire shift
- Two+persons physical assist d/t skin issues.
- Shower twice a week.
- Staff to take extra caution while providing showers due to skin issues.
- Staff to call BSO for support if they find resident #048 is exhibiting responsive behaviours during showers.

On July 11, 2016 interview with PSW #131 indicated that his/her understating that the resident requires two person assist with transfer from bed to the shower chair but not for the whole shower process. PSW #131 indicated that during the shower another PSW was available in the tub room assisting another resident with shower and that PSW was available to assist if needed. PSW #131 indicated the shower areas in the tub room were divided by privacy curtains.

On July 14, 2016 interview with PSW #145 indicated being aware that resident #048 needed two person assist with showers and that he/she assisted with transfer of resident to the shower chair and started shower with staff #131. PSW #145 indicated that he/she assisted in holding the shower chair as resident had a tendency to lean. PSW #145 further indicated that he/she had to leave the tub room to attend to another resident and on his/her way back he/she found that resident #048 had already fallen.

Review of progress notes for resident #048 indicated:
-on an identified date in 2016, RPN #135 documented that resident #048's substitute

decision maker (SDM) voiced some concerns regarding residents shower, as staff reported the resident can be resistive; BSO referral completed to asses resident during shower.
-on an identified date in 2016, RPN #136 documented that resident #048 was observed during shower, tolerated well. No responsive behaviours or distress noted.
-on an identified date in 2016, BSO/PSW #137 documented that resident #048 was observed during shower this morning, resident tolerated shower well. No responsive behaviors and no stiffness noted. Resident is a two person shower. BSO will update SDM with findings".

Review of MDS assessments (three most recent assessments) indicated the resident required physical help in part of bathing activity by two or more staff.

Review of the licensee's investigation notes and interview on July 14, 2016 with the DOC who explained at the time of the incident the resident's care plan indicated two person assist required for showers but was not clear to specify if the two person required for transfer or for the whole showering process. The plan of care has been updated following the incident to have two staff for the whole showering process due to poor control of a body part.

Resident #048's progress notes, MDS assessments and plan of care indicated the resident requires a minimum of two person assist for bathing/showering. Therefore, the plan of care was not followed as directed when resident #048 was assisted during a shower on an identified date in 2016 by one staff contrary to the directions in the plan of care of two or more persons. [s. 6. (7)] (570)

5. The licensee failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring the care set out in the plan of care was provided to residents #051, 065 and 066 as specified in the plan, related to Falls Prevention and Management.

Related to Log #014533-16 for resident #051:

Resident #051 had a diagnosis that included cognition impairment. Resident had been identified as a high risk for falls and required an assistive device for mobility.

Review of progress notes for resident #051 during a six months period indicated the resident sustained fifteen falls. Two of the documented falls indicated that the alarm was not attached or connected as follows:

-on an identified date in 2016 the "resident was observed laying on right side on floor of residents room". "It was suspected that resident was attempting to self-transfer from wheelchair to bed". "Resident alarm was not sounding, as it was not attached". The resident denied hitting a specified body part, no injuries noted and ROM completed and all extremities were within normal limits. Resident was assisted back to chair by two staff members.
-on a later identified date in 2016, the resident was found laying on the floor outside the floor mattress; was covered with bed sheets. The resident's bed alarm was not buzzing at the time of fall as it was not connected. As per PSW, the resident had an alarm at the beginning of the shift. The resident was noted groaning in pain when an identified body part was touched. The resident was assisted to wheelchair using lift with help of 3 staff, no skin tears and bruises noted, refused PRN Tylenol when offered. Denied pain, remained awake most of the shift calling out.

The plan of care dated (in place at time of above falls) indicated the following:
- Falls and or Balance – High Risk for falls. Interventions include: ensure that call bell within reach at all times; two staff for transfers & toileting; resident may try to self transfer and may fall, staff to know the resident whereabouts at all times; Bed/chair Alarm with string in place at all times.
- Safety Devices/Restraints - Interventions include: check resident when in bed hourly and record on hourly PASD sheet; encourage resident to use side-rail for repositioning self, provide resident with call bell when in bed (q1h while in bed), Registered staff will sign PASD sheet as per policy while device is in use (right side rail when in bed), falls mat in place, bed alarm in place for safety

The bed/chair alarm was not in place as per plan of care for resident #051 for the above two documented falls.

Related to Intake # 020874-16 for resident #065:

Critical Incident Report (CIR) was submitted to the Director on an identified date in 2016 due to an alleged neglect of resident #065 when staff noted the personal alarm for the resident was not working on identified date one day prior. The resident did not sustain a fall from this incident.

Resident #065 had diagnoses that include cognition impairment with history of previous injuries. Resident had been identified as at high risk for falls.

The current plan of care indicated the following:
- Falls and or Balance – High Risk for falls; interventions include: resident #065 is sliding out of wheelchair despite repositioned frequently by staff; Non Slip Mat placed on seat to prevent slipping off seat; Staff will continue to check and reposition resident #065 to ensure the resident is properly seated; Staff to ensure that alarming device is clipped to the resident when in wheel chair or bed; Staff to check Q shift that alarm is working.
- Safety devices/restraints - related to sliding out of wheelchair, will try to get self transfer from bed or wheelchair; interventions include: Staff to ensure that alarming device is clipped to resident #065 when up in wheelchair or bed, staff to check Q shift that alarming device is working.

On July 14, 2016 interview with the DOC indicated that PSW staff on July 12, 2016 at 2100 hours reported to RN #161 that resident #065's personal alarm was not working. The RN did not follow up on that until the issue was noted by the DOC while reviewing the 24 hours report.

During an interview on July 18, 2016, the DOC indicated the resident was already up in wheelchair the next morning of the incident date when batteries were replaced. The DOC indicated that RN #161 should have checked the alarm when PSW staff reported to him/her the resident's alarm was not working.

During an interview on July 15, 2016, RPN #104 indicated to inspector #641 that resident #065 had an alarm on the wheelchair because of sliding out of the chair.

On July 18, 2016 interview with RPN #104 and PSW #107 indicated to inspector #626 that resident #065 requires an alarm while in bed or chair due to high risk for falls.

Therefore, resident #065 who is identified as high risk for falls was not provided care as specified in the plan of care related to safety devices when the resident's personal alarm was discovered not working on an identified date till the next morning.

Related to Intake #020882-16 for resident #066:

Critical Incident Report (CIR) was submitted to the Director on an identified date in 2016 due to an alleged neglect of resident #066 identified at high risk for falls when the resident's personal alarm was taken away by staff and given to a co-resident two days prior. The resident did not sustain a fall from this incident.

Review of progress notes for resident #066 during a three months period in 2016 indicated the resident sustained one fall on an identified date with a minor injury to a body part.

The current plan of care for resident #066 indicated the following:
Falls and or Balance – Interventions include: Bed/chair alarm and fall mattress put in place. Ensure both are in place and working at all times.

On July 18, 2016 interview with RPN #156 indicated to inspector #626 that resident #066 had a chair and bed alarm as the resident had been known to slide out of the wheelchair and self transfer. PSW staff check alarms if functioning when they get the resident up and when providing care.

On July 18, 2016 interview with PSW #157 indicated to inspector #626 that resident #066 had an alarm that can be attached to the bed or the chair. The alarm was used as the resident forgets and bends forward or stands up and that will result in a fall.

The plan of care was not followed as directed when staff took away resident #066's personal alarm on an identified date leaving the resident without an alarm to alert staff until the situation was discovered and rectified by the DOC two days later. (570)

6. The licensee has failed to ensure that resident #056 was reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective.

Related to Log #016061-16 for resident #056:

Critical Incident Report (CIR) was submitted to the Director on an identified date for an alleged incident of staff to resident neglect occurring one day prior. The CIR indicated that resident #056 had been left on the toilet for an extended period of time from day shift until discovered by the evening shift. When assessed by a Physician one day later after the incident, the resident was weak. In addition, the resident was unable to void. The Physician instructed that the resident be sent to the hospital for assessment.

A review of the plan of care for resident #056 indicated the resident had multiple diagnoses including cognitive impairment. Before the incident, the resident was independent with mobility. The resident's toileting plan of care indicated: the resident was able to tell staff when needed to use the toilet; call bell was to be in reach and staff were to remind the resident to call when needed help; staff to provide assistance with

personal care; the resident will go to toilet and will not ask for assistance before using the toilet; the resident will often refuse care and assistance from staff; limited assistance by one staff member.

During the course of this inspection, Inspector #571 reviewed the following records belonging to resident #056: clinical records, including progress notes, flow sheets, Physician orders and notes, copies of hospital notes, and the licensee's investigation records. In addition, several staff members were interviewed. After review of these records and interviews it was determined the following staff were present and or discovered the incident: RPNs #133, #152, PSWs #147, #148, #150, RNs #149, #151.

-PSW #150 worked day shift on the day of the incident and was assigned as resident #056's care provider.

A review of the licensee's investigation notes for their interview with PSW #150, indicated that resident #056 was in the bathroom for an "extensive period of time" and that each time PSW #150 saw the resident, the resident was in the bathroom. She did not see the resident up and about. In addition, the resident did not receive breakfast or lunch, but was served fluids in the bathroom. PSW #150 indicated he/she reported to RPN #133 later that morning that the resident was in the bathroom and was still there later that morning. He/she indicated he/she checked on resident #056 at least every two hours. PSW #150 indicated that two staff members asked the resident to get off the toilet but the resident refused with no reasons given for this refusal.

In an interview with PSW #150, she indicated that resident #056 was observed on the toilet multiple times from morning until near the end of the day shift. PSW #150 only saw the resident on the toilet except when briefly observed the resident standing in the bathroom during the mid morning. PSW #150 informed RPN #133 that the resident was on the toilet and constipated in the morning. The resident did not go for breakfast or lunch which only happens rarely according to PSW #150. At the end of day shift, PSW #150 informed RPN #133 that the resident was appeared to be confused based on interactions with the resident during the day shift.

-RPN #133 worked day shift on the date of the incident and was the Charge Nurse for the unit on day shift where resident #056 resided.

A review of the licensee's investigation notes for their interview with RPN #133, indicated RPN #133 believed that resident #056 was on and off the toilet during the day shift. RPN

#133 was informed by PSW #150 during the mid morning that the resident was on the toilet and constipated and requested that RPN #133 assess the resident. RPN #133 assessed the resident and offered prune juice which the resident refused. At mid-day, PSW #150 reported that the resident was still on the toilet. At that time, RPN #133 assisted the resident with fixing pants and informed PSW #150 that the resident was ready to come for lunch. RPN #133 did not assess the resident after missing lunch and did not assess the resident at end of day shift after PSW #150 reported that resident #056 was confused.

In an interview, RPN #133 indicated that the resident was off and on the toilet most of the day shift. In early morning, RPN #133 assessed the resident's abdomen while sitting on the toilet, it was soft and gave the resident juice. At mid-day, the RPN gave the resident pants and told the resident to come for lunch then instructed PSW #150 to help the resident. RPN #133 informed Resident Care Area Manager (RCAM) #154 that the resident was up and down to the toilet at that time and RCAM #154 stated "okay". RPN #133 asked PSW #150 about the resident at mid-afternoon and was told the resident had gone back to bed but had gotten back up to the bathroom. The resident did not have breakfast or lunch. The RPN was not concerned about the resident missing breakfast and lunch despite being diabetic as the resident has "goodies" in room. Also, the RPN was not concerned about PSW #150's report that the resident was confused as the resident is normally confused.

In a progress note documented on the date of the incident, RPN #133 documented that the "resident was noticed sitting on toilet for most of the shift straining self". In addition, the RPN indicated the resident had ice cream and three units of fluid while sitting on toilet. Also, at end of day shift, the PSW reported that "resident is confused now. Will monitor."

The report sheet that the licensee uses to communicate between shifts was reviewed for the date of the incident. Under the heading "Days" an entry was noted stating that resident #056 had been on the toilet for a "long time straining self".

- PSW #147 started work on evening shift on day of the incident and was assigned to care for resident #056.

In a written statement taken after the incident by RN #151, PSW #147 indicated that PSW #150 had told evening staff in report that resident #056 had been on the toilet for a long time. She asked the resident if wanted to get off the toilet but the resident refused.

PSW #147 informed RPN #152 before supper that it was not good for the resident to be on the toilet that long and that they had to do something about it.

In an interview, PSW #147 indicated that all evening staff was informed by PSW #150 during report that resident #056 had been on the toilet for a long time. PSW #147 checked on the resident after rounds and informed RPN #152 that he/she was concerned about resident #056 and that the resident might need to go to the hospital. PSW #147 then asked PSW #148 to try to get the resident to come to the dining room for supper. PSW #148 was unsuccessful.

- RPN #152 worked evening shift on the date of the incident and was the Charge Nurse for the unit on evening shift where resident #056 resided.

In a written statement taken after the incident by RN #151, RPN #152 indicated that PSW #150 had reported that resident #056 was on the toilet straining for a long time. The RPN did not see the resident in the dining room for supper and the first time he/she saw the resident was after the meal service. The resident was confused, unable to stand and had a pulse of 124. RPN #152 immediately requested help from RN #151 and called Charge RN #149.

In an interview, RPN #152 indicated he/she had not realized that resident #056 had been on the toilet for a long time until PSW #148 informed him/her after the meal service that the resident was "still on the toilet". He/she asked PSW #148 what he/she meant by "still on the toilet" and was informed the resident had been there for some time. RPN #152 immediately went to resident #056's room and found the resident sitting on the toilet unable to stand up and confused.

In a progress note documented, RPN #152 documented that he/she was informed by staff that the resident had been sitting on the toilet since start of evening shift. He/she did not note the resident to be in distress. The resident was alert and responsive and indicated waiting for someone to bring a watermelon; denied pain or discomfort; could move both legs; had a pulse rate of 124; had two reddened area of two body parts.

-RN #151 happened to be at the nursing station on the date of incident in his/her capacity as Infection Control nurse.

In an interview, RN #151 indicated that RPN #152 requested help with resident #056. RN #151 indicated that he/she saw resident #056 with legs straightened out and was leaning

to one side; the resident did not make sense when spoke and was unable to stand. RN #151 advised the staff to assist the resident off the toilet with the mechanical lift. When the resident was raised RN #151 observed the resident’s body part was swollen. The resident was thirsty and drank several glasses of fluid before and after being put back to bed. A review of the written statement on the date of the incident from RN #151 indicated the same information.

-RN #149 was the Charge RN for the building and responded to the unit after being called.

In an interview with RN #149 indicated that he/she was called to the unit when received resident #056 on the toilet, alert and oriented but unable to walk. When the resident was assisted to bed via mechanical lift, RN #149 noted the resident to have swelling of an identified body part. Resident #056 was also complaining of pain which is unusual for the resident. A review of the written statement on the date of the incident from RN #149 that evening indicated the same information.

In an interview on July 12, 2016, the DOC indicated that as a result of the incident, resident #056 experienced the following outcomes:

-open areas to an identified body part; unable to void, although the DOC indicated she was not sure if the resident's inability to void occurred on the date of the incident or as a result of being on the toilet for an extended period of time; before the incident the resident was very mobile and could walk to the dining room, was able to get up to bathroom unassisted; after the incident the resident couldn't walk at all or only for a step or two; resident #056 is now more dependent for ADL's; the resident still cannot walk except in room.

After review of the clinical records and interviews, despite several inconsistencies in the evidence gathered, it is evident that that the following occurred:

- resident #056 did spend a long period of time on the toilet on an identified date but was checked on by staff
- no effective intervention was provided or offered to the resident to assist with passing stool except for an offer of prune juice nor was a physician contacted
- the resident is diabetic and missed breakfast, lunch and supper; the resident did receive ice cream and drinks while sitting on the toilet
- there was no evidence to support that the resident was assessed by the either RPN

#133 or #152 for an identified period of time.
-resident was able to ambulate independently to the dining room and around the unit before the incident. After the incident, the resident was treated at the hospital for not voiding and for constipation. In addition, the resident began to use a wheelchair after the incident and was only able to take steps in room as of this inspection on July 15, 2016.

Therefore, the licensee failed to ensure that resident #056 was reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective. [s. 6. (10) (c)] (571)

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that a drug was not administered to resident #004 unless it was prescribed.

Related to resident #004:

Review of the progress notes for resident #004 indicated on an identified day, Resident was supposed to receive a specific dose of diabetic medication at a specific time of day but instead was accidently given the wrong diabetic medication by the staff member . Resident was the one who alerted the staff member by stating "that's the wrong

medication". When resident pointed out the mistake the resident had already been administered the wrong medication. Immediately writer stopped giving the medication and notified supervisor of the mistake. Supervisor notified doctor and a new medication was ordered to give right away and it was given. No other changes were made. Resident continued with regular schedule of diabetic medication. Medication Incident report filled out. There was no indication the blood sugar was monitored both after the medication incident occurred or from the next shift.

Review of the health record for resident #004 indicated the resident is diagnosed with Diabetes Mellitus. The physician orders indicated the resident had specific diabetic medications to be administered at specific times of day, *HIGH ALERT; glucose monitoring is to be done twice daily; if resident is displaying signs of symptoms of hypoglycemia overnight, please do a glucometer check and record.

Review of the medication incident indicated resident #004 had received the wrong diabetic medication at a specific time of day as ordered by agency RPN #132. The incident report indicated the SDM and physician were notified soon after the medication error was identified, the Pharmacy and DOC notified later in the day.

Review of the glucose monitoring record for resident #004 indicated on the day of the incident, the blood sugar levels were taken as per original medical order, twice daily. A medication error occurred where the resident received the wrong diabetic medication.

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

1. Related to Critical Incident Log # 020155-16 for resident #029:

A critical incident report was received by the Director on an identified day for a medication incident/adverse drug reaction involving resident #029 that occurred on a specific day in 2016.

Review of the health care record for resident #029 indicated the resident had several diagnoses.

Review of the resident medication administration record (MAR) for a specific month in 2016 indicated the following medications were to be administered:

- cardiac medication to be given twice daily
- anticoagulant medication with alternating dosages to be given once a day
- a vitamin to be given once a day
- all other medications ordered to be given once a day

Review of the home's investigation, progress notes and interview of staff /resident indicated on an identified day, resident #029 had been administered by RPN #120 both doses of the cardiac medication at the same time, received the anticoagulant medication at the wrong time of day and received Vitamin at the wrong time of day. The resident began demonstrating lowered blood pressure and elevated heart rate later the same morning and the physician ordered vital signs checked every hour , hold an identified diuretic medication for 2-3 days, hold the anticoagulant medication for that day and call MD if systolic BP is below 90 . Two days later, an identified medication was reduced. There was no indication in the CIR that anticoagulant and vitamin were also given in error.

Review of the med cart on July 11, 2016 at 12:00 hrs for resident #029 indicated the resident still had an identified diuretic medication put on hold, in strip pack unopened and had a direction change sticker in place. An identified cardiac medication for a specific administration time was not available.

Review of the MAR indicated the diuretic medication was discontinued and a new order for the diuretic medication was to be administered at a specific time.

Interview with RPN #121 indicated on July 11, 2016 she had signed the MAR at 08:00 as giving the diuretic medication but could not indicate why the medication was still in the strip pack. The RPN indicated she thought the diuretic medication had been discontinued but then indicated after reviewing the physician order that she had completed a medication error by omitting to administer the new order at the specified time as ordered. The RPN indicated no action taken regarding the cardiac medication being unavailable until after discussion with the inspector when the drug was ordered from the pharmacy.

Related to resident #052:

Interview with RPN #121 also indicated on July 11, 2016 resident #052 did not receive an identified medication for a specific time as ordered as it was not available in the strip pack and the RPN documented on the MAR as not available. The RPN indicated she had

not taken any other action related to the medication not being administered.

Review of the medication strip pack for resident #052 indicated the identified medication was available for two other administration times in the package. Review of physician order for resident #052 indicated the resident was to receive the identified medication three time daily 30 minutes pre-meals.

Review of the healthcare record for resident #052 indicated the resident was diagnosed with specified medical condition for which the medication was prescribed. (111)

2. Related to Log #018031-16

On July 13, 2016 Inspector #541 was on Pine unit at approximately 1130 hours and overheard a family member of resident #044 indicated the resident had not had breakfast as of 1000 hours and had not received the morning medication as of that time.

Inspector #541 reviewed the Medication Administration Record (MAR) for resident #044 for July 13, 2016. The resident was to receive the four identified medications at 0800 hours. All four of the medications were not administered until 1033 hours.

The MAR for resident #064 and resident #068 were also reviewed and revealed the following:

Resident #064 was scheduled to receive an identified medication at 0800 hours. The medication was not administered until 1121 hours.

Resident #068 was scheduled to receive five identified medication, including a narcotic, at 0800 hours.

Resident # 068 was administered all the five identified medications at 1113 hours. It was also noted that a narcotic medication was administered at 1113 hours for the 0800 hour scheduled administration and was then administered again at 1127 hours for the 1200 hour scheduled administration time.

The Nurse Consultant #162 indicated in an interview on August 30, 2016, that the licensee's expectation for administration of medication is that a nurse must give medication as per the Medication Administration Record within one hour before or after

medication administration time. (571)

The medication administration time for residents #029, 052, 044, 064, and 068 was outside the parameter of the one hour window before or after the prescribed time of administration as per the licensee's expectation. (570) [s. 131. (2)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".
DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas were locked to restrict unsupervised access to those areas by residents.

Throughout the Resident Quality Inspection, unsupervised access to non-residential areas of the home was observed. The following was noted:

- a door at the back of the enclosed courtyard off of the Atrium was unlocked; this door lead to the retirement home where an unlocked door in a stairwell lead to the back of the home.

- the door from the dining room to the kitchenette on the Cedar unit was also observed propped open with no staff present on three separate occasions and was accessible to residents as the dining room door was unlocked.

Therefore, the licensee failed to lock the identified doors to restrict unsupervised access to non-residential areas by residents. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that all doors leading to non-residential areas are locked to restrict unsupervised access to those areas by residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the elevators were equipped to restrict access to areas that were not to be accessed by residents.

During this inspection the following issues were observed:

- the elevator between the Birch and Cedar units lead to the basement which is a non-resident area; this area did not have hand rails or a call system; within this area, Inspector #571 was able to access several storage rooms, one of which contained paint, paint thinners and solvents. In addition, the electrical/boiler room, the garbage room and three unlocked doors to the outside were accessible. Staff were not present to supervise the area.

- the elevator between the Birch and Cedar units also allowed access to the kitchenettes on the Cedar and Aspen units via the rear door of the elevator on the second and first floor; these kitchenettes contained steam tables, coffee makers, hot water machine, a house keeping closet and dish room-the steam table, coffee maker, and hot water machine were observed on in the kitchenettes. Staff were not present to supervise the area.

Therefore, the licensee failed to equip the elevator noted above to restrict access to areas that were not to be accessed by residents. [s. 10. (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 by ensuring that elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring resident #066's wheelchair was maintained in a safe condition and in a good state of repair.

Related to Log # 020874-16 for resident #066:

Review of progress notes for resident #066 during a three months period in 2016, indicated the following:
- on a specified date and time, resident sustained a fall. The progress note indicated after the resident was transferred to the wheelchair, the chair tipped backwards. The anti-tippers on the wheelchair were loose and turned up causing the chair to flip backwards. A small red area was noted on the back of resident's head.
- on that same day, a few hours after the fall, RPN #159 documented the physiotherapist indicated the anti-tippers should lock in place, and these did not. The physiotherapist was to speak with technician in regards to ordering new anti-tippers.
- on same day, soon after the physiotherapist assessment, resident #066's manual wheelchair was seen by the Occupational Therapist (OT) #160 due to a report that the resident tipped backwards with his/her wheelchair. The wheelchair's anti-tippers did not seem to belong to the wheelchair itself; anti-tippers should also lock in place and the pair on the resident's wheelchair did not. The OT notified Motion Specialties, mobility equipment technician, to have the anti- tippers replaced with the appropriate type for client's brand of wheelchair.
- 21 days later, OT #160 received reports that resident #066 has been sliding forward in wheelchair. The resident continued to have complaints about the wheelchair: ROHO cushion was overinflated and the OT took some air out while the resident was out of the wheelchair; back support brackets were tightened by the technician from Motion Specialties; The technician also recommended for the rear wheels to be moved back

slightly to make the wheelchair more stable and less likely to tip; The OT was to follow up with the resident during next visit.

On July 18, 2016 at 1300 hours, inspector #626 noted the anti-tippers located at the back of resident #066's wheelchair were loose. The anti-tip guard on the left side was loose and turned inwards. The right anti-tip guard was loose and shorter than the right side. RPN #156 attempted to adjust the anti-tippers but was not effective. RPN #156 indicated to inspector #626 that the resident required a new wheelchair but the family refused to replace the wheelchair.

On July 18, 2016 at 1407 hours, inspector #570 observed resident #066's manual wheelchair while the resident was in bed; the wheelchair had two anti-tippers; inspector noted that both anti-tippers were loose and were not locking in place and did not prevent the wheelchair from being tipped backwards.

On July 18, 2016 interview with physiotherapist (PT) #155 in relation to resident #066's wheelchair indicated to inspector #570 that the anti-tippers did not seem to lock in place to prevent the wheelchair from tipping backwards. PT #155 indicated the anti-tippers needed to be fixed and that he would contact the vendor and would ask the OT to have a look at the wheelchair.

Record review and staff interviews failed to indicate that resident #066's wheelchair was repaired to ensure resident's safety and reduce the risk for tipping backwards when in the wheelchair. [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 resident #066's wheelchair is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

During this inspection the following issues were observed:

- an enclosed courtyard accessible by residents through the Pine unit on the main floor did not contain a resident-staff communication and response system so that residents could call for help if necessary; signage posted on the door indicated that the door to this courtyard was left unlocked from 0830 to 1630 hours; this courtyard was observed unsupervised by staff.

- an enclosed courtyard accessible by residents through the Atrium on the first floor did not contain a resident-staff communication and response system so that residents could call for help if necessary; signage posted on the door indicated that the door to this courtyard is unlocked from 0830 to 2030 hours; this courtyard was observed unsupervised by staff; the first floor is accessible to residents via the main elevator or stairs in the dining room.

- an enclosed balcony on the Cedar unit had an unlocked door and it was accessible to residents; no resident-staff communication and response system was available for residents to call for help if necessary.

Therefore, the licensee failed to ensure the resident-staff communication and response system is available in two courtyards and one balcony accessible by residents. [s. 17. (1) (e)]

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 by ensuring that resident-staff communication and response system is available in every area accessible by residents including enclosed courtyards and balconies, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the policy to minimize the restraining of residents was complied with. s. 29 (1) (b)

Related to resident #020:

A review of the health records indicated that resident #020 was admitted to the home on an identified day in 2016 with diagnoses which includes Dementia. Resident #020 used a wheelchair with the capacity to tilt/recline for mobility.

On July 8, 2016, the resident was observed sitting in his/her wheelchair which was in the tilt or reclining position. A review of the resident's health record determined that there was no order or consent for the tilt wheelchair. There was also no documented information in the resident's plan of care pertaining to the use of this device as a restraint or Personal Assistive Safety Device (PASD).

During an interview on July 8, 2016, PSW #110 indicated that the tilt wheelchair was used for the resident as a PASD. Interview with RPN #109 indicated that the tilt wheelchair was not used for resident #020 as a restraint or PASD and should not be placed in the tilt or reclining position. RPN #109 also confirmed there were no physician's or nursing with extended class order, consent from the SDM and plan of care for the tilt wheelchair.

The licensee's Physical Restraint Policy, Reference #RESI-10-01-01, Version – November 2012 list of approved physical restraints, to include the front closing seatbelt, tilt feature, when engaged, on a wheelchair or geriatric chair. The home's Physical Restraint Policy also outlines that a physician's or nursing order, consent and plan of care is required for use of a restraint. [s. 29. (1) (b)]

2. Related to resident #002

A review of the health records indicated that resident #002 was admitted to the home on a specified date in 2010 with diagnoses which includes cognitive impairment.

The review of health records information indicated that resident #002 used one side rail in the up position for bed mobility and a lap tray used for maintaining position, while in the wheelchair as PASDs. The resident was observed on July 6, 2016, by inspector #641 wearing a seatbelt while up in the wheelchair.

Resident #002 was observed sitting in his/her wheelchair on July 6, 7, 8 and 11, 2016 wearing an alarm seatbelt. On July 8, 2016 the RN #114 in the presence of inspector #626 gently pulled the alarm seatbelt forward and the seatbelt did not open or unlock. Resident #002 was asked to remove the alarm seatbelt and was unable to remove the belt. In separate interviews on July 8, 2016 PSW #119 and RN #114 both confirmed that resident #002 did not have a restraint but did have bed rail and lap tray as PASDs.

Registered Nurse (RN) #114 also identified the alarm seatbelt was a PASD. On review of resident #002 health records, the alarm seatbelt was noted as a fall prevention strategy in the plan of care and not as a restraint or PASD. There was no consent from the SDM or physician order for the device.

The licensee's Physical Restraint Policy, Reference #RESI-10-01-01, Version – November 2012 list of approved physical restraints, to include the front closing seatbelt, tilt feature, when engaged, on a wheelchair or geriatric chair. The home's Physical Restraint Policy also outlines that a physician's or nursing order, consent and plan of care is required for use of a restraint.

AliMed manufacturer information provided by the Administrator on July 8, 2016 indicate the E-Z Release Seatbelt is not a restraint and is designed to be easily opened and removed by most residents.

On July 11, 2016, the DOC indicated that the alarm seatbelt will open, if the residents attempts to stand. On July 11, 2016, the resident attempted to stand with PSW #119 present and the alarm seatbelt did not loosen or unlock and prevented the resident from standing. [s. 29. (1) (b)]

3. Related to resident #012:

A review of the health records indicated that resident #012 was admitted to the home on a specified date in 2014, with diagnoses which includes Alzheimer disease.

On July 6, 2016 resident #012 was observed sitting in wheelchair with an alarm front closure seat belt which was loose and improperly applied. The resident was observed pulling on the alarm seat belt. During a second observation on July 6, 2016, inspector(s) #626 and #571 were unable to loosen or open the alarm seat belt by gently pulling it forward. On July 7 and 8, 2016, resident #012 was observed in the wheelchair which was in the tilt/reclining position and the alarm seat belt was properly applied. On July 8, 2016 RN #114 gently pulled the alarm seat belt forward and was unable to loosen or unlock the device.

On review of resident #012 health records, the alarm seat belt was noted in the plan of care as a safety and fall prevention strategy but not as a restraint or PASD. There was no consent from the SDM or physician order for the alarm seat belt. There was no physician order documented for the tilt wheelchair.

AliMed manufacturer information provided by the Administrator on July 8, 2016 indicate the E-Z Release Seat belt is not a restraint and is designed to be easily opened and removed by most residents.

In an interview on July 11, 2016 RN #114 indicated that the alarm seat belt was not considered to be restraint because the belt will open or unlock, if the resident attempts to stand. On July 11, 2016 the DOC confirmed that the alarm seat belt will open if the residents attempts to stand.

The licensee's Physical Restraint Policy, Reference #RESI-10-01-01, Version – November 2012 list of approved physical restraints, to include the front closing seat belt, tilt feature, when engaged, on a wheelchair or geriatric chair. The home's Physical Restraint Policy also outlines that a physician's or nursing order, consent and plan of care is required for use of a restraint. [s. 29. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Physical Restraint Policy #RESI-10-01-01 is complied with, specifically as it relates to:
- Restraining of a resident is ordered or approved by a physician or registered nurse in the extended class;
- Restraining of a resident is consented by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent; and
- Restraining of the resident is included in the plan of care and provides for all the requirements under s.31 of the LTCHA, 2007 Act, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan:
(c) promotes continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident and
(d) includes a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8(3) of the Act, cannot come to work
(e) gets evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices

Related to Log #018031-16

An anonymous complaint was received indicating that the home was short staffed at times and as a result, resident care was affected.

On July 13, 2016 Inspector #552 was informed by staff on Pine unit that they were working short. Inspector #552 was informed they normally had six PSWs on the unit and they only had four. Staff indicated the PSWs normally had eleven residents assigned to them but they had to pick up an additional 3-4 residents each.

On July 13, 2016 Inspector #541 was on Pine unit at approximately 1130 hours and overheard a family member of resident #044 indicated the resident had not had breakfast as of 1000 hours and had not received the morning medication as of that time.

Inspector #541 reviewed the Medication Administration Record (MAR) for resident #044 for July 13, 2016. The resident was to receive the four identified medications at 0800 hours. All four of the medications were not administered until 1033 hours.

The MAR for resident #064 and resident #068 were also reviewed and revealed the following:

Resident #064 was scheduled to receive an identified medication at 0800 hours. The medication was not administered until 1121 hours.

Resident #068 was scheduled to receive five identified medication, including a narcotic, at 0800 hours.

Resident # 068 was administered all the five identified medications at 1113 hours. It was also noted that a narcotic medication was administered at 1113 hours for the 0800 hour

scheduled administration and was then administered again at 1127 hours for the 1200 hour scheduled administration time.

On July 13, 2016 at approximately 0930 hours this inspector requested the staffing plan from the home's Administrator and was provided with the master schedule document for the month of July 2016. The document represents the staffing schedule for registered and non registered staff for the month of July 2016. Inspector #541 asked for the home's staffing plan and was provided with a document titled: Quality Program Evaluation - Nursing and PSW staffing services. This document is an overview of any staffing concerns identified during the month of May 2016.

Inspector #541 reviewed regulation 31(3) with the home's administrator and asked for the home's staffing plan that contains the information as required as per O. Regulation 79/10 s. 31.

On July 13, 2016 Inspector #570 spoke with the Administrator regarding the staffing plan during which time the Administrator stated she will put something in writing for inspector. The Administrator further stated that the staff are aware of what to do when there is a shortage.

On July 14, 2016 Inspector #541 was provided with an undated document titled Nursing and Personal Support Contingency Plan as the home's staffing plan.

All three documents identified as part of the staffing plan and provided to Inspector #541 as part of the staffing plan did not provide documented evidence of the following as required under O. Regulation 79/10 s. 31(3):

- O. Reg 79/10 s. 31(3)c Promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident.

- O. Reg 79/10 s. 31(3)d include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8(3) of the Act, cannot come to work. [s. 31. (3)]

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 by ensuring the staffing plan in the home:
- promotes the continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident,
- includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work, and
- gets evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The Licensee has failed to comply with O. Reg. 79/10, s. 68 (2) (a) by not ensuring policies and procedures relating to nutrition care and dietary services and hydration are implemented in consultation with a registered dietitian who is a member of the staff of the home.

Inspector #541 requested the home's weight change policy from the Food Service Manager and was provided with policy #RESI-05-02-07 titled Weight Change Program.

Page 1 of the policy, under Procedures stated that registered nursing staff:
1. Compare to previous month's weight; and any weight with a 2.5 kg difference from the previous month requires a re-weigh. Registered staff is to direct care staff to re-weigh the resident.

Resident # 008's weights were reviewed for a three months period in 2016. Resident #008 was noted to have a significant weight change of 4.3 kg between two consecutive months in 2016. The home's Registered Dietitian assessed resident #008's weight loss on a specified month and indicated that the weight done in previous month was likely an error, there was no re-weigh completed.

Resident #22's weights were reviewed for a four months period in 2016; Between two specified consecutive months in 2016 resident was noted to differ by 2.9 kg and there is no documented re-weigh completed. Between two other consecutive months in 2016, resident #022's weight was noted to differ by 6.4 kg (9.95%) and no documented re-weigh was completed. Resident #022's significant weight change was assessed by the home's Registered Dietitian.

Resident #002's weights were reviewed for four months period in 2015/2016; Between two consecutive identified months, resident #002's weights differed by 24.3 kg and no documented re-weigh was completed.

On July 11, 2016 inspector #541 interviewed the home's Registered Dietitian (RD) regarding the expectations when a resident's weight varies greatly from the previous month. The RD stated the expectation was that if the resident's weight differs by 2.5 kg or more from the previous month's weight, then a re-weigh would be completed. (541) [s. 68. (2) (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 by ensuring policies and procedures relating to nutrition care and dietary services and hydration specific to Weight Change Program is complied with, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to immediately forward a written complaint that had been received concerning the care of a resident or the operation of the home to the Director.

Related to Log #019532-16 for resident #061:

A review of the health records indicated that resident #061 was admitted to the home on an identified date in 2015 with diagnoses which includes cognition impairment. The resident was discharged from the home after 16 months since admission.

In the course of inspecting complaint Log #019532-16 pertaining to resident #061, which involved concerns about the discharge of the resident from the home, an additional complaint was made by the substitute decision maker (SDM) of resident #061. The complainant indicated that a complaint letter was sent to the home by e-mail in an identified date one month prior to discharge regarding a comment made to paramedics by a PSW student.

In an interview on July 14, 2016 the DOC confirmed the complaint received by e-mail from the complainant was treated as a verbal complaint and was not immediately forwarded to the Director. [s. 22. (1)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (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 the results of every investigation for allegations of abuse and neglect involving residents and the actions taken were reported to the Director

Related to Log #012213-16 for resident #046:

Critical Incident Report (CIR) was reported to the Director on an identified date for an incident of alleged neglect. The CIR indicated that a family member found resident #046 sitting in the lounge with soiled clothing.

On July 08, 2016, during an interview, the Director of Care indicated to Inspector #571 that after the investigation, she was unable to determine that neglect had occurred and that she failed to report the results of the investigation to the Director.

Therefore, the licensee failed to report to the Director the result of the investigation into the identified incident and the actions taken in response to this same incident. [s. 23. (2)]

2. Related to Log # 003951-16 for resident #041:

Critical Incident Report (CIR) was reported to the Director on an identified date for an allegation of neglect occurring on the same day. The CIR indicated that resident #041 complained that the night shift staff did not toilet him/her after ringing the call bell.

On July 08, 2016, during an interview, the Director of Care indicated to Inspector #571 that after the investigation of the allegation of neglect, no evidence of neglect was found. The DOC confirmed that the results of the investigation was not reported to the Director.

Therefore, the licensee failed to report to the Director the result of the investigation into the identified incident and the actions taken in response to this same incident.

The above incidents occurred prior to the due date of Compliance Order (CO #001), under LTCHA, 2007, s. 19, issued during inspection #2015_365194_0028 on Jan 15, 2016 with a compliance date of April 30, 2016. The Compliance Order was found to be in compliance during this inspection, therefore no additional action is required at this time. [s. 23. (2)]

WN #12: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(ii) names of any staff members or other persons who were present at or discovered the incident.

Related to Log # 019889-16 for resident #057:

A critical incident report was received by the Director on an identified date for an allegation of neglect that occurred earlier on that same day. The CIR indicated resident #057 is high risk for falls and was found with personal alarming device "may not have been turned on". The resident did not sustain a fall. The CIR indicated the staff had been re-instructed to assess at beginning of shift all residents at high risk for falls to ensure personal safety device is in place and working. The CIR did not identify the staff member involved in the incident.

Related to Log #019887-16 for resident #058:

A critical incident report (CIR) was received by the Director on an identified date for an allegation of staff to resident neglect that occurred on earlier that same day. The CIR indicated resident #058 is at high risk for falls and was to wear a personal alarming

device. The resident was found with personal alarm device not turned on. The resident did not sustain a fall.The CIR did not identify the staff member involved in the allegation.

Interview of DOC on July 13, 2016 indicated an investigation was completed regarding the incidents that occurred on an identified date with resident #057 and resident #058 and staff involved in both incidents were PSW # 138 & #139. The DOC indicated both staff received disciplinary action as result of failing to ensure alarming device was checked at beginning of each shift and activated. [s. 104. (1) 2.]

2. Related to Log # 019884-16 for resident #062:

A critical incident report (CIR) was submitted to the Director on an identified date for an allegation of staff to resident neglect that occurred on that same day. The CIR indicated that resident #062 sustained a fall with no injury and determined a staff member failed to ensure resident #062 personal alarming device was turned on. The resident was a high risk for falls. The CIR did not indicate which staff was present when the incident occurred.

On July 13, 2016 interview with the DOC and review of the licensee's investigation indicated it was improper care and not neglect and PSW #140 was present when the fall occurred and was not identified on the CIR.

Related to Intake # 020497-16 for resident #062:

Critical Incident Report (CIR) was submitted to the Director on an identified date due to an alleged neglect of resident #062 when the personal alarm for the resident was not turned on that same day.

The Critical Incident Report failed to identify all staff members that were present or discovered the incident. The DOC did not add information related to the staff identified as PSW, RPN and RN on the CIR submitted to the MOHLTC [s. 104. (1) 2.]

3. Related to Intake # 020874-16 for resident #065:

Critical Incident Report (CIR) was submitted to the Director on an identified date due to an alleged neglect of resident #065 when staff noted the personal alarm for the resident was noted not working on an identified date (one day prior to submission date) and reported the issue to the RN supervisor.

The Critical Incident Report failed to identify all staff that were present or discovered the incident. The DOC identified the RN supervisor (RN #161) but did not add information related to the staff who discovered and reported the incident to the RN #161 on the CIR submitted to the MOHLTC [s. 104. (1) 2.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 107. (3) 4, by not ensuring that the Director was informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident was taken to a hospital.

Related to Log #014533-16 for resident #051:

A critical Incident Report (CIR) was received on an identified date in 2016 for resident #051's fall sustained on an identified date in 2015.

Review of the CIR and progress notes for resident #051 indicated the resident had a confirmed diagnosis of an injury to a body part on an identified date in 2015 when the resident was transferred to hospital for assessment due to complaints of increased pain in a body part.

Therefore the Director was not notified of the incident involving resident #051until the CIR was submitted on an identified date in 2016 after over twelve months of the resident's confirmed injury. [s. 107. (3)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate actions are taken in response to medication incident involving resident #004.

Related to resident #004:

Review of the progress notes for resident #004 indicated on an identified day, Resident was supposed to receive a specific dose of diabetic medication at a specific time of day but instead was accidently given the wrong diabetic medication by the staff member. Resident was the one who alerted the staff member by stating "that's the wrong medication". When resident pointed out the mistake the resident had already been administered the wrong medication.. Immediately writer stopped giving the medication and notified supervisor of the mistake. Supervisor notified doctor and a new medication was ordered to give right away and it was given. No other changes were made. Resident continued with regular schedule of diabetic medication. Medication Incident report filled out. There was no indication the blood sugar was monitored both after the medication incident occurred or from the next shift.

Review of the health record for resident #004 indicated the resident is diagnosed with Diabetes Mellitus. The physician orders indicated the resident had specific diabetic medications to be administered at specific times of day, *HIGH ALERT; glucose monitoring is to be done twice daily; if resident is displaying signs of symptoms of hypoglycemia overnight, please do a glucometer check and record.

Review of the medication incident indicated resident #004 had received the wrong diabetic medication at a specific time of day as ordered by agency RPN #132. The incident report indicated the SDM and physician were notified soon after the medication error was identified, the Pharmacy and DOC notified later in the day.

Review of the glucose monitoring record for resident #004 indicated on the day of the incident, the blood sugar levels were taken as per original medical order, twice daily. A medication error occurred where the resident received the wrong diabetic medication with no indication the blood sugar was monitored both after the medication incident occurred or from the next shift in relation to the medication error.

Therefore, the resident was not reassessed for glucose monitoring when a medication incident occurred where the resident received the wrong insulin and the wrong dose and the medication is considered a high alert medication. (111) [s. 134. (b)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that before discharging a resident under subsection 145 (1) a written notice was provided to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

Complaint Log #019532-16 was initiated by the substitute decision maker (SDM) of resident #061 in relation to concerns about the discharge of the resident from the home.

A review of the health records indicated that resident #061 was admitted to the home on an identified date in 2015 with multiple diagnoses which includes cognition impairment. The Administrator and Director of Care determined that the home could no longer meet

the needs of the resident. Subsequently, the resident was discharged from the home on an identified date in 2016 after 16 months from admission date. The resident is now receiving care in an alternative setting.

The review of health records information indicated that resident #061 demonstrated responsive behaviours toward staff. There were no documented incidents involving residents. The resident was sent to hospital on a Form 1 on four occasions in two months period prior to discharge for responsive behaviours. Resident #061 was involved in incidents which resulted in an injury of staff. The home provided Incident Reports for three employees and one PSW student who were injured by the resident.

A review of health records revealed that the resident was provided with one-on-one supervision, Ontario Shores Centre for Mental Health Sciences services, Psychiatrist and the BSO team was involved with the resident. On July 14, 2016, the Administrator provided written notation of the meeting on early date of the month of discharge with the SDM, indicating the SDM was informed the home was unable to meet the needs of the resident and would request appropriate placement for the resident through CCAC.

During another interview on July 14, 2016, the SDM indicated to inspector #626 that the meeting held on an identified date (month of discharge), discussed the resident's behaviour, Ontario Shores and sending the resident out to hospital. Noted in the progress notes on an identified date, the DOC documented the SDM and CCAC were informed that based on resident #06's unprovoked, unpredictable responsive behaviours, the resident would be transferred to hospital and will be discharged from the home. According to documentation in the progress notes, the physician also contacted CCAC on an identified date (month of discharge) and spoke with a placement coordinator. During the conversation, the physician informed the placement coordinator that despite medical management and non-pharmacological measures, the resident's behaviour posed a risk and discussed the option of discharging the resident from the facility.

The resident was transferred to hospital on an identified date in 2016 and was discharged from the home. One day following discharge date a letter was sent to Ontario Shores outlining the resident's condition and behaviour and reason for discharge; this letter was also sent to the family. The SDM indicated the letter was sent to the resident's spouse who is not the SDM; This letter was received four or five days following discharge date.

The Administrator confirmed that a letter was sent to the resident's mailing address one

day following discharge date, indicating that the resident was discharged, after the resident was discharged from the home. [s. 148. (2)]

Issued on this 9th day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SAMI JAROUR (570), AMBER LAM (541), CATHI KERR (641), DENISE BROWN (626), LYNDA BROWN (111), MARIA FRANCIS-ALLEN (552), PATRICIA MATA (571)
Inspection No. / No de l'inspection :	2016_327570_0014
Log No. / Registre no:	008633-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 8, 2016
Licensee / Titulaire de permis :	CVH (No.6) GP Inc. as general partner of CVH (No.6) LP c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6
	Angela Rodrigues

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Order / Ordre :

The licensee shall prepare, submit and implement a corrective action plan for the following:

- develop and implement an RN/RPN-led monitoring process for front line staff to demonstrate that all safety equipment related to falls, including alarming devices, are applied and functioning at the beginning of each shift and more frequently based on the resident's assessed needs

- develop and implement a communication and reporting protocol between PSW's, RPN's and RN's so that information regarding residents identified at moderate or high risk for falls and residents exhibiting new potentially harmful responsive behaviours or a significant change in condition, is clear, accurate and acted upon immediately, including updating of plan of care

The corrective action plan is to be submitted to Sami Jarour via email to OttawaSAO.MOH@ontario.ca by September 23, 2016.

Grounds / Motifs :

1. 1. The licensee has failed to ensure the plan of care was provided to residents #002, 057, 058 and 062 as specified in the plan related to falls prevention and management.

Related to Log #019833-16 for resident #002:

A critical incident report was received by the Director on an identified date in 2016 for a fall incident involving resident #002. The CIR indicated the resident #002 sustained a fall from wheelchair near the nursing station as the resident was to have a personal alarm in place and the alarm was not activated as it was not turned on. The resident was a high risk for falls. No injury was sustained as a

result of the fall.

Review of the progress note for resident #002 following the fall indicated the staff heard the resident's attachment to the wheelchair falling on the floor. The resident then reached for the bar and then slipped to the floor from the wheelchair. No injuries noted. The seat belt alarm was not reset and PSW re-educated re: important to reset the seat belt alarm. Post fall huddle done. Fall factor checklist, Scott Falls assessment and post fall investigation completed. Fall tracking sheet updated and care plan updated.

Review of the current plan of care for resident #002 indicated under safety devices/restraints that attachment to wheelchair is used when up in wheelchair as PASD for maintaining position. Interventions included resident has tendency to remove safety devices including alarming device. Ensure that alarming device is initiated when in wheelchair/bed. Under falls/balance, high risk for falls, sustained falls on eleven identified dates. Interventions include: check every hour, falls prevention interventions in place: safety devices including alarming device, resident removes safety devices and staff to ensure that all are in place and reapply if removed.

Therefore, resident #002's plan of care was not followed when sustained a fall on an identified date as alarming device was applied but not activated to alert staff.

Related to Log # 019889-16 for resident #057:

A critical incident report was received by the Director on an identified date of 2016 for an allegation of neglect that occurred on same date. The CIR indicated resident #057 is high risk for falls and was found with personal alarming device that "may not have been turned on". The resident did not sustain a fall. The CIR indicated the staff had been re-instructed to assess at beginning of shift all residents at high risk for falls to ensure personal safety device is in place and working.

Review of the current plan of care for resident #057 indicated the resident is a high risk for falls related to weakness and high Scott's falls risk assessment score. Under Safety Devices/Restraints due to attempting to self transfer. Interventions included: alarming devices in place at all times; Keep door open to ensure staff hear alarm; Staff to check alarms every shift that they are turned on

and functioning properly; resident will unclip personal alarm and self transfer to the bathroom-staff to make sure to put clip alarm at the back- away from resident's reach.

The resident was not provided care as specified in the plan related to safety devices when the alarming device was applied but not turned on to alert staff.

Related to Log #019887-16 for resident #058:

A critical incident report was received by the Director on an identified date in 2016 for an allegation of staff to resident neglect that occurred earlier on same day. The CIR indicated resident #058 is at high risk for falls and was to wear a personal alarming device. The resident was found with personal alarm device not turned on. The resident did not sustain a fall.

Review of the current plan of care for resident #058 indicated the resident was a high risk for falls related to history of falls on seven identified dates during a four months period in 2016 and Scott's fall risk screen. Under safety devices/restraints related to falls risk. Interventions included: has a floor mat down when in bed, mat should be taken up and put out of the way when up; to wear a personal alarm when in chair or bed. Staff to respond to alarm and make sure that resident #058 always gets assistance while using toilet.

On an identified date, the resident was not provided care as set out in the plan of care related to safety devices when the personal alarm device was not turned on.

Related to Log # 019884-16 for resident #062:

A critical incident report was submitted to the Director on an identified date in 2016 for an allegation of staff to resident neglect that occurred earlier same day. The CIR indicated that resident #062 sustained a fall with no injury and determined a staff member failed to ensure resident #062 personal alarming device was turned on. The resident was a high risk for falls.

Review of the current plan of care for resident #062 indicated the resident was a high risk for falls related to identified multiple diagnosis, history of falls, and Scott's fall risk screen. Interventions included alarming device and staff to ensure the device is on at all times, check that all alarms are working and

activated. (111)

On an identified date, resident #062 was not provided care as set out in the plan of care related to safety devices when the personal alarming device was not turned on.

Related to Log # 020497-16 for resident #062:

Critical Incident Report was submitted to the Director on an identified date in 2016 due to an alleged neglect of resident #062 specific to the resident's personal alarm not turned on when staff saw the resident walking out from room with the alarm not ringing. The resident did not sustain a fall related to this incident.

Review of clinical records for resident #062 indicated the resident had multiple diagnoses that include cognition impairment; the resident had been identified as a high risk for falls related to history of falling and other impairments. The resident was readmitted to the home following recent hospitalization on an identified date in 2016 and since then the resident had gotten frail and weak.

On July 14, 2016 interview with PSW #144 indicated to Inspector #641 that resident #062 was at high risk for falls and that alarming devices were in place, a fall's mat on the floor, and staff were to put the bed in the lowest position when the resident was in bed.

On July 18, 2016 at 1035 hours interview with RPN #158 indicated to inspector #626 that resident #062 used a personal alarm when in bed and chair to alert staff for falls prevention.

On July 18, 2016 interview with PSW #144 indicated to inspector #626 that resident #062 had a chair alarm due to risk of falling. The PSW indicated the alarm is checked every hour.

The alarming device was not turned on as directed in the plan of care for resident #062 on an identified date when the resident was noticed by staff walking without the alarm ringing to alert staff.

The resident was not provided care as specified in the plan of care related to safety devices when resident #062's alarming device was not turned on to alert

staff on two identified dates.

2. The licensee failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring the care set out in the plan of care was provided to resident #048 as specified in the plan, related to bathing and falls prevention.

Related to Log #013742-16 for resident #048:

Critical Incident Report (CIR) indicated on an identified date in 2016, personal support worker (PSW) #131 was assisting resident #048 with shower when the shower chair tipped over with the resident still in it. The resident sustained an injury to a body part.

Review of clinical records for resident #048 indicated was admitted with multiple diagnosis including cognitive impairment.

Review of clinical records and interviews on July 11 and 14, 2016 with PSWs #124,131 and 145 indicated resident #048 is totally dependent in activities of daily living.

Review of resident #048's plan of care in effect at time of the incident indicated the resident was at moderate risk for falls. The plan of care indicated the following interventions under bathing and shampooing:
- Total dependence. Full staff performance of activity during entire shift
- Two+persons physical assist d/t skin issues.
- Shower twice a week.
- Staff to take extra caution while providing showers due to skin issues.
- Staff to call BSO for support if they find resident #048 is exhibiting responsive behaviours during showers.

On July 11, 2016 interview with PSW #131 indicated that his/her understating that the resident requires two person assist with transfer from bed to the shower chair but not for the whole shower process. PSW #131 indicated that during the shower another PSW was available in the tub room assisting another resident with shower and that PSW was available to assist if needed. PSW #131 indicated the shower areas in the tub room were divided by privacy curtains.

On July 14, 2016 interview with PSW #145 indicated being aware that resident #048 needed two person assist with showers and that he/she assisted with

transfer of resident to the shower chair and started shower with staff #131. PSW #145 indicated that he/she assisted in holding the shower chair as resident had a tendency to lean. PSW #145 further indicated that he/she had to leave the tub room to attend to another resident and on his/her way back he/she found that resident #048 had already fallen.

Review of progress notes for resident #048 indicated:
-on an identified date in 2016, RPN #135 documented that resident #048's substitute decision maker (SDM) voiced some concerns regarding residents shower, as staff reported the resident can be resistive; BSO referral completed to asses resident during shower.
-on an identified date in 2016, RPN #136 documented that resident #048 was observed during shower, tolerated well. No responsive behaviours or distress noted.
-on an identified date in 2016, BSO/PSW #137 documented that resident #048 was observed during shower this morning, resident tolerated shower well. No responsive behaviors and no stiffness noted. Resident is a two person shower. BSO will update SDM with findings".

Review of MDS assessments (three most recent assessments) indicated the resident required physical help in part of bathing activity by two or more staff.

Review of the licensee's investigation notes and interview on July 14, 2016 with the DOC who explained at the time of the incident the resident's care plan indicated two person assist required for showers but was not clear to specify if the two person required for transfer or for the whole showering process. The plan of care has been updated following the incident to have two staff for the whole showering process due to poor control of a body part.

Resident #048's progress notes, MDS assessments and plan of care indicated the resident requires a minimum of two person assist for bathing/showering. Therefore, the plan of care was not followed as directed when resident #048 was assisted during a shower on an identified date in 2016 by one staff contrary to the directions in the plan of care of two or more persons. [s. 6. (7)] (570)

3. The licensee failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring the care set out in the plan of care was provided to residents #051, 065 and 066 as specified in the plan, related to falls prevention and management.

Related to Log #014533-16 for resident #051:

Resident #051 had a diagnosis that included cognition impairment. Resident had been identified as a high risk for falls and required an assistive device for mobility.

Review of progress notes for resident #051 during a six months period indicated the resident sustained fifteen falls. Two of the documented falls indicated that the alarm was not attached or connected as follows:
-on an identified date in 2016 the "resident was observed laying on right side on floor of residents room". "It was suspected that resident was attempting to self-transfer from wheelchair to bed". "Resident alarm was not sounding, as it was not attached". The resident denied hitting a specified body part, no injuries noted and ROM completed and all extremities were within normal limits. Resident was assisted back to chair by two staff members.
-on a later identified date in 2016, the resident was found laying on the floor outside the floor mattress; was covered with bed sheets. The resident's bed alarm was not buzzing at the time of fall as it was not connected. As per PSW, the resident had an alarm at the beginning of the shift. The resident was noted groaning in pain when an identified body part was touched. The resident was assisted to wheelchair using lift with help of 3 staff, no skin tears and bruises noted, refused PRN Tylenol when offered. Denied pain, remained awake most of the shift calling out.

The plan of care dated (in place at time of above falls) indicated the following:
- Falls and or Balance – High Risk for falls. Interventions include: ensure that call bell within reach at all times; two staff for transfers & toileting; resident may try to self transfer and may fall, staff to know the resident whereabouts at all times; Bed/chair Alarm with string in place at all times.
- Safety Devices/Restraints - Interventions include: check resident when in bed hourly and record on hourly PASD sheet; encourage resident to use side-rail for repositioning self, provide resident with call bell when in bed (q1h while in bed), Registered staff will sign PASD sheet as per policy while device is in use (right side rail when in bed), falls mat in place, bed alarm in place for safety

The bed/chair alarm was not in place as per plan of care for resident #051 for the above two documented falls.

Related to Intake # 020874-16 for resident #065:

Critical Incident Report (CIR) was submitted to the Director on an identified date in 2016 due to an alleged neglect of resident #065 when staff noted the personal alarm for the resident was not working on identified date one day prior. The resident did not sustain a fall from this incident.

Resident #065 had diagnoses that include cognition impairment with history of previous injuries. Resident had been identified as at high risk for falls.

The current plan of care indicated the following:
- Falls and or Balance – High Risk for falls; interventions include: resident #065 is sliding out of wheelchair despite repositioned frequently by staff; Non Slip Mat placed on seat to prevent slipping off seat; Staff will continue to check and reposition resident #065 to ensure the resident is properly seated; Staff to ensure that alarming device is clipped to the resident when in wheel chair or bed; Staff to check Q shift that alarm is working.
- Safety devices/restraints - related to sliding out of wheelchair, will try to get self transfer from bed or wheelchair; interventions include: Staff to ensure that alarming device is clipped to resident #065 when up in wheelchair or bed, staff to check Q shift that alarming device is working.

On July 14, 2016 interview with the DOC indicated that PSW staff on July 12, 2016 at 2100 hours reported to RN #161 that resident #065's personal alarm was not working. The RN did not follow up on that until the issue was noted by the DOC while reviewing the 24 hours report.

During an interview on July 18, 2016, the DOC indicated the resident was already up in wheelchair the next morning of the incident date when batteries were replaced. The DOC indicated that RN #161 should have checked the alarm when PSW staff reported to him/her the resident's alarm was not working.

During an interview on July 15, 2016, RPN #104 indicated to inspector #641 that resident #065 had an alarm on the wheelchair because of sliding out of the chair.

On July 18, 2016 interview with RPN #104 and PSW #107 indicated to inspector #626 that resident #065 requires an alarm while in bed or chair due to high risk for falls.

Therefore, resident #065 who is identified as high risk for falls was not provided care as specified in the plan of care related to safety devices when the resident's personal alarm was discovered not working on an identified date till the next morning.

Related to Intake #020882-16 for resident #066:

Critical Incident Report (CIR) was submitted to the Director on an identified date in 2016 due to an alleged neglect of resident #066 identified at high risk for falls when the resident's personal alarm was taken away by staff and given to a co-resident two days prior. The resident did not sustain a fall from this incident.

Review of progress notes for resident #066 during a three months period in 2016 indicated the resident sustained one fall on an identified date with a minor injury to a body part.

The current plan of care for resident #066 indicated the following:
Falls and or Balance – Interventions include: Bed/chair alarm and fall mattress put in place. Ensure both are in place and working at all times.

On July 18, 2016 interview with RPN #156 indicated to inspector #626 that resident #066 had a chair and bed alarm as the resident had been known to slide out of the wheelchair and self transfer. PSW staff check alarms if functioning when they get the resident up and when providing care.

On July 18, 2016 interview with PSW #157 indicated to inspector #626 that resident #066 had an alarm that can be attached to the bed or the chair. The alarm was used as the resident forgets and bends forward or stands up and that will result in a fall.

The plan of care was not followed as directed when staff took away resident #066's personal alarm on an identified date leaving the resident without an alarm to alert staff until the situation was discovered and rectified by the DOC two days later. (570)

4. The licensee has failed to ensure that resident #056 was reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective.

Related to Log #016061-16 for resident #056:

Critical Incident Report (CIR) was submitted to the Director on an identified date for an alleged incident of staff to resident neglect occurring one day prior. The CIR indicated that resident #056 had been left on the toilet for an extended period of time from day shift until discovered by the evening shift. When assessed by a Physician one day later after the incident, the resident was weak. In addition, the resident was unable to void. The Physician instructed that the resident be sent to the hospital for assessment.

A review of the plan of care for resident #056 indicated the resident had multiple diagnoses including cognitive impairment. Before the incident, the resident was independent with mobility. The resident's toileting plan of care indicated: the resident was able to tell staff when needed to use the toilet; call bell was to be in reach and staff were to remind the resident to call when needed help; staff to provide assistance with personal care; the resident will go to toilet and will not ask for assistance before using the toilet; the resident will often refuse care and assistance from staff; limited assistance by one staff member.

During the course of this inspection, Inspector #571 reviewed the following records belonging to resident #056: clinical records, including progress notes, flow sheets, Physician orders and notes, copies of hospital notes, and the licensee's investigation records. In addition, several staff members were interviewed. After review of these records and interviews it was determined the following staff were present and or discovered the incident: RPNs #133, #152, PSWs #147, #148, #150, RNs #149, #151.

-PSW #150 worked day shift on the day of the incident and was assigned as resident #056's care provider.

A review of the licensee's investigation notes for their interview with PSW #150, indicated that resident #056 was in the bathroom for an "extensive period of time" and that each time PSW #150 saw the resident, the resident was in the bathroom. She did not see the resident up and about. In addition, the resident did not receive breakfast or lunch, but was served fluids in the bathroom. PSW #150 indicated he/she reported to RPN #133 later that morning that the resident was in the bathroom and was still there later that morning. He/she indicated he/she checked on resident #056 at least every two hours. PSW #150 indicated that two staff members asked the resident to get off the toilet but the resident

refused with no reasons given for this refusal.

In an interview with PSW #150, she indicated that resident #056 was observed on the toilet multiple times from morning until near the end of the day shift. PSW #150 only saw the resident on the toilet except when briefly observed the resident standing in the bathroom during the mid morning. PSW #150 informed RPN #133 that the resident was on the toilet and constipated in the morning. The resident did not go for breakfast or lunch which only happens rarely according to PSW #150. At the end of day shift, PSW #150 informed RPN #133 that the resident was appeared to be confused based on interactions with the resident during the day shift.

-RPN #133 worked day shift on the date of the incident and was the Charge Nurse for the unit on day shift where resident #056 resided.

A review of the licensee's investigation notes for their interview with RPN #133, indicated RPN #133 believed that resident #056 was on and off the toilet during the day shift. RPN #133 was informed by PSW #150 during the mid morning that the resident was on the toilet and constipated and requested that RPN #133 assess the resident. RPN #133 assessed the resident and offered prune juice which the resident refused. At mid-day, PSW #150 reported that the resident was still on the toilet. At that time, RPN #133 assisted the resident with fixing pants and informed PSW #150 that the resident was ready to come for lunch. RPN #133 did not assess the resident after missing lunch and did not assess the resident at end of day shift after PSW #150 reported that resident #056 was confused.

In an interview, RPN #133 indicated that the resident was off and on the toilet most of the day shift. In early morning, RPN #133 assessed the resident's abdomen while sitting on the toilet, it was soft and gave the resident juice. At mid-day, the RPN gave the resident pants and told the resident to come for lunch then instructed PSW #150 to help the resident. RPN #133 informed Resident Care Area Manager (RCAM) #154 that the resident was up and down to the toilet at that time and RCAM #154 stated "okay". RPN #133 asked PSW #150 about the resident at mid-afternoon and was told the resident had gone back to bed but had gotten back up to the bathroom. The resident did not have breakfast or lunch. The RPN was not concerned about the resident missing breakfast and lunch despite being diabetic as the resident has "goodies" in room. Also, the RPN was not concerned about PSW #150's report that the

resident was confused as the resident is normally confused.

In a progress note documented on the date of the incident, RPN #133 documented that the "resident was noticed sitting on toilet for most of the shift straining self". In addition, the RPN indicated the resident had ice cream and three units of fluid while sitting on toilet. Also, at end of day shift, the PSW reported that "resident is confused now. Will monitor."

The report sheet that the licensee uses to communicate between shifts was reviewed for the date of the incident. Under the heading "Days" an entry was noted stating that resident #056 had been on the toilet for a "long time straining self".

- PSW #147 started work on evening shift on day of the incident and was assigned to care for resident #056.

In a written statement taken after the incident by RN #151, PSW #147 indicated that PSW #150 had told evening staff in report that resident #056 had been on the toilet for a long time. She asked the resident if wanted to get off the toilet but the resident refused. PSW #147 informed RPN #152 before supper that it was not good for the resident to be on the toilet that long and that they had to do something about it.

In an interview, PSW #147 indicated that all evening staff was informed by PSW #150 during report that resident #056 had been on the toilet for a long time. PSW #147 checked on the resident after rounds and informed RPN #152 that he/she was concerned about resident #056 and that the resident might need to go to the hospital. PSW #147 then asked PSW #148 to try to get the resident to come to the dining room for supper. PSW #148 was unsuccessful.

- RPN #152 worked evening shift on the date of the incident and was the Charge Nurse for the unit on evening shift where resident #056 resided.

In a written statement taken after the incident by RN #151, RPN #152 indicated that PSW #150 had reported that resident #056 was on the toilet straining for a long time. The RPN did not see the resident in the dining room for supper and the first time he/she saw the resident was after the meal service. The resident was confused, unable to stand and had a pulse of 124. RPN #152 immediately requested help from RN #151 and called Charge RN #149.

In an interview, RPN #152 indicated he/she had not realized that resident #056 had been on the toilet for a long time until PSW #148 informed him/her after the meal service that the resident was "still on the toilet". He/she asked PSW #148 what he/she meant by "still on the toilet" and was informed the resident had been there for some time. RPN #152 immediately went to resident #056's room and found the resident sitting on the toilet unable to stand up and confused.

In a progress note documented, RPN #152 documented that he/she was informed by staff that the resident had been sitting on the toilet since start of evening shift. He/she did not note the resident to be in distress. The resident was alert and responsive and indicated waiting for someone to bring a watermelon; denied pain or discomfort; could move both legs; had a pulse rate of 124; had two reddened areas of two body parts.

-RN #151 happened to be at the nursing station on the date of incident in his/her capacity as Infection Control nurse.

In an interview, RN #151 indicated that RPN #152 requested help with resident #056. RN #151 indicated that he/she saw resident #056 with legs straightened out and was leaning to one side; the resident did not make sense when spoke and was unable to stand. RN #151 advised the staff to assist the resident off the toilet with the mechanical lift. When the resident was raised RN #151 observed the resident's body part was swollen. The resident was thirsty and drank several glasses of fluid before and after being put back to bed. A review of the written statement on the date of the incident from RN #151 indicated the same information.

-RN #149 was the Charge RN for the building and responded to the unit after being called.

In an interview with RN #149 indicated that he/she was called to the unit when received resident #056 on the toilet, alert and oriented but unable to walk. When the resident was assisted to bed via mechanical lift, RN #149 noted the resident to have swelling of an identified body part. Resident #056 was also complaining of pain which is unusual for the resident. A review of the written statement on the date of the incident from RN #149 that evening indicated the same information.

In an interview on July 12, 2016, the DOC indicated that as a result of the

incident, resident #056 experienced the following outcomes:

-open areas to an identified body part; unable to void, although the DOC indicated she was not sure if the resident's inability to void occurred on the date of the incident or as a result of being on the toilet for an extended period of time; before the incident the resident was very mobile and could walk to the dining room, was able to get up to bathroom unassisted; after the incident the resident couldn't walk at all or only for a step or two; resident #056 is now more dependent for ADL's; the resident still cannot walk except in room.

After review of the clinical records and interviews, despite several inconsistencies in the evidence gathered, it is evident that that the following occurred:

- resident #056 did spend a long period of time on the toilet on an identified date but was checked on by staff
- no effective intervention was provided or offered to the resident to assist with passing stool except for an offer of prune juice nor was a physician contacted
- the resident is diabetic and missed breakfast, lunch and supper; the resident did receive ice cream and drinks while sitting on the toilet
- there was no evidence to support that the resident was assessed by the either RPN #133 or #152 for an identified period of time.
-resident was able to ambulate independently to the dining room and around the unit before the incident. After the incident, the resident was treated at the hospital for not voiding and for constipation. In addition, the resident began to use a wheelchair after the incident and was only able to take steps in room as of this inspection on July 15, 2016.

Therefore, the licensee failed to ensure that resident #056 was reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective. [s. 6. (10) (c)] (571)

An order is issued due to the severity, scope and history of the non-compliance found in relation to plan of care. Non-compliance with plan of care was identified involving multiple residents. Due to this non-compliance, there was a potential risk of harm to residents when their care and safety needs are not met. In addition, resident #056 was actually harmed when the plan of care was not revised when ineffective and resident #048 was actually harmed when the care plan was not followed as directed. In addition, a review of the compliance history

of the licensee indicated the following ongoing non-compliance related to plan of care: June 23, 2015, Inspection # 2015_360111_0014 compliance order issued under s. 6. (10); July 30, 2015, Inspection # 2015_293554_0009 compliance order issued under s. 6 (2); January 15, 2016, Inspection #2015_365194_0028 compliance order issued under s. 6 (2). (570)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_360111_0009, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Order / Ordre :

The licensee shall:

- immediately upon being served with this Compliance Order conduct a 15 day audit of current electronic medication administration records (eMar) for all residents receiving a specified diabetic medication including resident #004 to assess accuracy in diabetic medication administration.

- develop and implement a monitoring process to ensure all residents receiving a specified diabetic medication including resident #004 are receiving the right diabetic medication at the right dose, using the right route at the specified time as prescribed specifically when the medication is administered to residents by registered nursing staff specifically by new registered nursing staff or an agency or casual registered nursing staff.

Grounds / Motifs :

1. The licensee failed to ensure that a drug was not administered to resident #004 unless it was prescribed.

Related to resident #004:

Review of the progress notes for resident #004 indicated on an identified day, Resident was supposed to receive a specific dose of diabetic medication at a specific time of day but instead was accidently given the wrong diabetic medication by the staff member . Resident was the one who alerted the staff member by stating "that's the wrong medication". When resident point out the

mistake the resident had already been administered the wrong medication. Immediately writer stopped giving the medication and notified supervisor of the mistake. Supervisor notified doctor and a new medication was ordered to give right away and it was given. No other changes were made. Resident continued with regular schedule of diabetic medication. Medication Incident report filled out. There was no indication the blood sugar was monitored both after the medication incident occurred or from the next shift.

Review of the health record for resident #004 indicated the resident is diagnosed with Diabetes Mellitus. The physician orders indicated the resident had specific diabetic medications to be administered at specific times of day, *HIGH ALERT; glucose monitoring is to be done twice daily; if resident is displaying signs of symptoms of hypoglycemia overnight, please do a glucometer check and record.

Review of the medication incident indicated resident #004 had received the wrong diabetic medication at a specific time of day as ordered by agency RPN #132. The incident report indicated the SDM and physician were notified soon after the medication error was identified, the Pharmacy and DOC notified later in the day.

Review of the glucose monitoring record for resident #004 indicated on the day of the incident, the blood sugar levels were taken as per original medical order, twice daily. A medication error occurred where the resident received the wrong diabetic medication. (111)

The decision to re-issue an order is based on resident #004 receiving the wrong insulin and the wrong dose putting the resident at risk of harm specifically when there was no indication the resident's blood sugar was monitored both after the medication error occurred or from the next shift. This history of repeated non-compliance, along with the scope and risks associated with the noted medication administration practices in the home were considered when the decision to re-issue this CO was made. (570)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

- immediately upon being served with this Compliance Order and for 15 consecutive days after that date, conduct a daily audit of at least 10 percent of the electronic medication records (eMar) currently in use in each of the six Resident Home Areas (RHA) to assess accuracy;

- ensure that the eMar audit process includes a visual verification of all key elements of the medication administration process, including but not limited to ensuring that the right resident is receiving the right medication, at the right dose, using the right route at the specified time;

- take effective corrective actions when registered nursing staff are not administering medication in line with legislative requirements, established practice standards, policies or procedures; and

- review the current medication administration routines to ensure appropriate support systems are in place when employing new or casual nurses or when the usual RN/RPN deployment pattern is altered.

Grounds / Motifs :

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

1. Related to Critical Incident Log # 020155-16 for resident #029:

A critical incident report was received by the Director on an identified day for a

medication incident/adverse drug reaction involving resident #029 that occurred on a specific day in 2016.

Review of the health care record for resident #029 indicated the resident had several diagnoses.

Review of the resident medication administration record (MAR) for a specific month in 2016 indicated the following medications were to be administered:
- cardiac medication to be given twice daily
- anticoagulant medication with alternating dosages to be given once a day
- a vitamin to be given once a day
- all other medications ordered to be given once a day

Review of the home's investigation, progress notes and interview of staff /resident indicated on an identified day, resident #029 had been administered by RPN #120 both doses of the cardiac medication at the same time, received the anticoagulant medication at the wrong time of day and received Vitamin at the wrong time of day. The resident began demonstrating lowered blood pressure and elevated heart rate later the same morning and the physician ordered vital signs checked every hour , hold an identified diuretic medication for 2-3 days, hold the anticoagulant medication for that day and call MD if systolic BP is below 90 . Two days later, an identified medication was reduced. There was no indication in the CIR that anticoagulant and vitamin were also given in error.

Review of the med cart on July 11, 2016 at 12:00 hrs for resident #029 indicated the resident still had an identified diuretic medication put on hold, in strip pack unopened and had a direction change sticker in place. An identified cardiac medication for a specific administration time was not available.

Review of the MAR indicated the diuretic medication was discontinued and a new order for the diuretic medication was to be administered at a specific time.

Interview with RPN #121 indicated on July 11, 2016 she had signed the MAR at 08:00 as giving the diuretic medication but could not indicate why the medication was still in the strip pack. The RPN indicated she thought the diuretic medication had been discontinued but then indicated after reviewing the physician order that she had completed a medication error by omitting to administer the new order at the specified time as ordered. The RPN indicated no action taken regarding the

cardiac medication being unavailable until after discussion with the inspector when the drug was ordered from the pharmacy.

Related to resident #052:

Interview with RPN #121 also indicated on July 11, 2016 resident #052 did not receive an identified medication for a specific time as ordered as it was not available in the strip pack and the RPN documented on the MAR as not available. The RPN indicated she had not taken any other action related to the medication not being administered.

Review of the medication strip pack for resident #052 indicated the identified medication was available for two other administration times in the package. Review of physician order for resident #052 indicated the resident was to receive the identified medication three time daily 30 minutes pre-meals.

Review of the healthcare record for resident #052 indicated the resident was diagnosed with GERD. (111)

2. Related to Log #018031-16

On July 13, 2016 Inspector #541 was on Pine unit at approximately 1130 hours and overheard a family member of resident #044 indicated the resident had not had breakfast as of 1000 hours and had not received the morning medication as of that time.

Inspector #541 reviewed the Medication Administration Record (MAR) for resident #044 for July 13, 2016. The resident was to receive the four identified medications at 0800 hours. All four of the medications were not administered until 1033 hours.

The MAR for resident #064 and resident #068 were also reviewed and revealed the following:

Resident #064 was scheduled to receive an identified medication at 0800 hours. The medication was not administered until 1121 hours.

Resident #068 was scheduled to receive five identified medication, including a

narcotic, at 0800 hours.

Resident # 068 was administered all the five identified medications at 1113 hours. It was also noted that a narcotic medication was administered at 1113 hours for the 0800 hour scheduled administration and was then administered again at 1127 hours for the 1200 hour scheduled administration time.

The Nurse Consultant #162 indicated in an interview on August 30, 2016, that the licensee's expectation for administration of medication is that a nurse must give medication as per the Medication Administration Record within one hour before or after medication administration time. (571)

The medication administration time for residents #029, 052, 044, 064, and 068 was outside the parameter of the one hour window before or after the prescribed time of administration as per the licensee's expectation. (570)

This order is issued under s.131(2) because the licensee was previously ordered to develop and implement a monitoring process to ensure that all medications are administered to all residents in accordance with the direction for use, and as specified by the prescriber during inspection #2015_365194_0028 with a compliance date of February 29, 2016 and then re-issued during inspection #2016_360111_0009 with a compliance date of May 26, 2016. This history of repeated non-compliance, along with the scope and risks associated with the noted medication administration practices in the home were considered when the decision to issue this CO was made. (570)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

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

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

Issued on this 8th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sami Jarour

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 25, 2016	2016_327570_0021	002610-16	Follow up

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 04-07, 2016 and October 11, 2016

Follow up inspection Log #002610-16 related to compliance order #005 issued under inspection #2015_365194_0028 regarding the home, furnishings and equipment not maintained in a safe condition and in a good state of repair with a compliance date of July 31, 2016.

During the course of the inspection, the inspector(s) spoke with Administrator, the licensee`s Regional Director, Director of Care (DOC), Residents, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nurse Administrative Assistant, Environmental Services Supervisor (ESS), Housekeeping staff and the Pharmacist.

During the course of this inspection, the inspector toured the home, observed staff to residents interactions and provision of care; reviewed clinical health records of identified resident, relevant policies, housekeeping and maintenance audit records, staff educational records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Medication
Safe and Secure Home

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

As a result of the Resident Quality inspection (RQI) #2015_365194_0028 conducted in November 2015, the licensee was served with a Compliance Order (#005) on January 31, 2016 with an initial compliance date of April 30, 2016. The licensee requested an extension to July 31, 2016 which was agreed upon. The licensee was ordered to ensure that a monitoring process is in place to assess the effectiveness of the housekeeping and maintenance practices in the home. The monitoring process will include a method:
-to ensure that the "deep cleaning policies and practices for the home are implemented and complied with.
-to ensure that re-education is provided, to all departments related to the process for "PM Works", which is the electronic Maintenance requisitions used in the home
-to ensure that the ESM is conducting weekly audits related the home furnishings and equipment being kept clean, sanitary, safe and in a good state of repair.
-Monthly analysis of all PM works received, is completed to identify and address any deficiencies.

During this follow up inspection, the following observations were made, during the period of October 4-6, 2016:

Linden unit:
- TV Lounge area: scraped paint with water damage to window sill with wood exposed; damaged flooring (gouged and cracked with black marks noted) around the middle of the TV lounge area.
- Tub/Shower room: Lower wall damage to wall tiles at corners in three areas;
- In an identified resident's room: ripped laminate flooring in bathroom (about 10 cm).
- In an identified resident's room: gap between floor and base board with dirt accumulating; new white tiles (3 tiles) installed with no grout; space visible between tiles; broken 2 tiles next to vanity with missing pieces exposing the under surface.
- In an identified resident's room: ripped laminate flooring next to toilet base exposing the under surface; broken tile with missing piece next to window exposing the under surface (corner bead);
- In an identified resident's room: noted missing base board at corner next to bathroom door frame exposing a rusted corner bead.

- In an identified resident's room: scraped paint of lower wall above baseboard.

Birch unit:
- In an identified resident's room: scraped paint of lower wall; dark blackish brown staining surrounding base of toilet and surrounding flooring.
- In an identified resident's room: baseboard is lifting at lower corner next bath room exposing the under surface (corner bead).
- In an identified resident's room: lower door frame is chipped.
- In an identified resident's room: the covering of the lower door of the room is loose and chipped creating sharp edges. Lower door frame guard is chipped with sharp edges noted. Scraped paint of lower bathroom door; the bathroom does not close properly; corners of the door are chipped with wood exposed.
- Dry wall damage to lower wall in hallway across from an identified resident's room.
- Water damage/scraped paint with wood exposed of window sill in hallway next to an identified resident's room.
- In two identified residents' rooms – damage to lower door frame guard.
- Damage to lower wall at corners at patio door with rusted corner bead exposed in Birch TV lounge/activity room.

Maple unit:
- Dry wall damage to corner (mid wall) exposing corner bead next to an identified resident's room.
- Dry wall damage to wall corners at entrance of two identified residents' rooms.
- Scraped paint of lower bathroom door of a resident room; Brown stains with small holes on floor from a previously installed commode chair in bathroom.
- Tub room for Maple and Birch units - brown staining on the floor in tub area; gap between floor and wall at entrance of shower area exposing the under surface with dirt accumulating; damaged cover of the light switch; brown stain around toilet base in shower area; missing corner guard of short wall in toilet area; lower wall covering is lifting above baseboard; missing piece of baseboard at entrance of shower area exposing the under surface.
- Brown stains on floor in hallway of Maple unit at entrance of main dining room.

Pine unit:
- Missing hand rail (3 meters long) with 4 holes in dry wall at entrance of Pine unit.
- Scraped paint of lower walls (gouged) above baseboard; chipped lower wooden frame at entrance of Pine TV lounge;
- Tub/Bathing area: Drywall damage to lower wall in toilet area exposing corner bead that

was noticed dented inwards; brownish/rust like stain around toilet base; Brown/rust stains around shower/tub; damaged lower corner at sitting/tub shower area exposing drywall and rusted corner bead; damaged wall at corners exposing damaged corner beads at tub room entrance; dry wall damage to lower wall between tub room and shower room.
- Scrapped lower wall next to bathroom door of a resident's room.
- Damage to dry wall in hallway with a hole in dry wall about 10x10 cm behind hand railing next to an identified resident's room.
Aspen unit:
- Spa room: broken multiple tiles (lower row) in tub room with gap noted between floor and tile walls (wall with windows); unfinished dry wall repair at entrance of Spa room (not painted); damage to lower wall at baseboard between tub room and shower room; Damage to lower wall at baseboard at entrance of spa room exposing a dented corner bead; Scraped paint of lower door of spa room; dry wall damage to lower wall in hallway at storage door next to Aspen spa room.
- In two identified residents' rooms; door guard / plastic covering of lower wall is loose and lifting creating sharp corners. Missing lower door plastic covering of two residents' rooms (under surface of brown glue is exposed);
- Damage to corner at door frame of the dining room exposing corner bead of lower and mid wall.

On October 05, 2016 the Environmental Services Supervisor (ESS) indicated to the inspector that maintenance staff become aware of areas in need of repair by accessing PM Works (electronic maintenance requisition software) several times a day for repair with anything resident related or high risk area will be fixed within 24 hours.

On October 05, 2016, inspector #570 interviewed the Administrator and the Extendicare Regional Director. The Administrator indicated the preventative maintenance program of the home is included in the PM Works for day to day maintenance schedule and also includes what was scheduled weekly or monthly for preventative maintenance. The Regional Director indicated that the focus was on repairing the deficiencies identified in the MOHLTC inspection report issued in January 2016 and the repairs to those deficiencies were completed. The Administrator further indicated that it is the expectation that all repairs were to be identified and completed; for that a maintenance supervisor was hired in August 2016 so that repairs can be done by maintenance staff if possible and to avoid bringing in contractors unless needed; it was taking too much time for contractors to finish needed repairs; also staff are encouraged to input all needed repairs using the PM works.

On October 05, 2016, during a tour of the Spa room in Pine unit and lounge area in Linden unit with the Regional Director, Administrator and Environmental Services Supervisor (ESS) all indicated that they were not aware of the Pine unit and Linden unit. The regional director indicated to the inspector that the spa room in Pine unit was recently repaired and the damage noted to walls was new. The ESS confirmed to the inspector that none of the damages noted in the Pine spa room and Linden TV lounge were reported to maintenance staff by using the PM Works software. The ESS further indicated that the expectation of the home is that staff will continue to use PM works to communicate needed repairs to the maintenance staff.

The compliance order was served on January 31, 2016 with a compliance date extended until July 31, 2016 required weekly audits and monthly analysis to be completed. Review of the audits provided to inspector indicated that audits were not completed during the months of April and July 2016 and the audits provided were not completed weekly as required by the compliance order and there were no audits completed for common areas. The resident room sanitation and room repair audits were completed on the following dates during the period of January 31, 2016 to July 31, 2016:
Feb 22, 25, 26; March 8, 11, 17; May 16; June 15 and 21, 2016.

On October 06, 2016 interview with the Administrator and and the ESS both indicated to the inspector that issues identified requiring repair (damaged walls in SPA room in Pine unit) was not communicated to maintenance staff through the PM Works software; also not all issues identified by inspector were reported in PM works. The Administrator further indicated that she had no evidence that monthly analysis was completed as required by the order and that her expectation was that the former Environmental Services Manager (ESM) but was unable to provide any documentation.

The decision to re issue the compliance order was based on the widespread deficiencies related to the home , furnishings and equipment not being maintained in a safe condition and in a good state of repair identified during this inspection and the licensee's failure to comply with the requirements of the previous compliance order issued in January 2016 under inspection #2015_365194_0028. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 122.(1), by not ensuring that no drug is acquired, received or stored by or in the home or kept by a resident unless the drug:
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply, and
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario.

Related to resident #002

On October 11, 2016 at about 1430 hours the following was witnessed by inspector #570:
Resident #002 came to the nursing station on an identified unit and handed a box of prescription drug (controlled substance) to RPN #112. The box was noted to be sealed. Resident #002 told RPN #112 that PSW #113 gave the box to him/her and that he/she was surprised that the box was delivered to him/her.

On October 11, 2016, RPN #112 indicated to the inspector that staff #114 gave the box of a prescription drug (controlled substance) to PSW #113 who gave it to resident #002; later RPN #112 indicated he/she phoned the pharmacy who indicated that the box was sent to the home by a taxi driver with instructions to be delivered to the unit's Charge Nurse. RPN #112 indicated that he/she called the pharmacy for the prescription drug (controlled substance) today and this package should have been delivered to the RPN

and if the RPN was not available it should have been delivered to one of the Residents Care Area Managers (RCAM). RPN #112 indicated to the inspector that the package was sealed.

On October 11, 2016 at about 1450 hours during an interview with PSW #113, it was indicated to the inspector that at about 1415 hours, Staff #114 gave him/her a package to be delivered to resident #002 and that he/she was not aware of the content of the package.

On October 11, 2016 at about 1500 hours during an interview with resident #002, it was indicated to the inspector that he/she gets the prescription drug (controlled substance) every 3 days and that the medication helps with pain. The resident also indicted that he/she was aware of the content of the package and that he/she was concerned if the package had fallen into the wrong hands.

On October 11, 2016 at about 1517 hours during an interview with staff #114 it was indicated to the inspector that a gentleman came to the door and delivered a package to him/her and said, no signature was required when asked. Staff #114 indicated to the inspector no awareness that the package included a prescription drug (controlled substance).

On October 11, 2016 at about 1612 hours during an interview with the home's contracted pharmacist, he indicated to the inspector that he was made aware of the prescription drug (controlled substance) box that was not delivered to Registered Nurse and was not signed off by a Registered Nurse. The pharmacist indicated that the expectations were that the taxi driver should have followed instructions and delivered the package to a Registered Nurse and should have gotten a signature; the nurse has to sign for it and add it to the controlled substances count. The Pharmacist indicated to the inspector that those were the instructions given by the pharmacy to the taxi driver; however, those instructions were not followed by the taxi driver.

The licensee failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident when a package of prescription drug (controlled substance) was delivered to non-registered staff at the home and later delivered to resident #002 before the package was secured by RPN #112. [s. 122. (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 there is a process in place and monitored, ensuring that no drug is acquired, received or stored by or in the home or kept by a resident unless the drug:
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply, and
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 14, by not ensuring each resident shower have at least two easily accessible grab bars, one grab bar located on the same wall as the faucet and one grab bar located on the adjacent wall.

On October 04, 2016 during an observation of the bathing areas located at the Pine and Linden units, inspector #570 noted the shower areas in both units did not have a shower grab bar located on the adjacent wall of the faucet.

On October 4, 2016 Personal Support Worker (PSW) #110 indicated to the inspector the shower area in Pine unit was used in the morning to provide showers to residents.

On October 05, 2016 Environmental Services Supervisor (ESS) indicated to the inspector that he was aware that two grab bars are required in shower areas but was not aware that shower grab bars were not installed at the adjacent wall of the faucet in the two identified shower areas. [s. 14.]

Issued on this 7th day of December, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2016_327570_0021
Log No. / Registre no:	002610-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 25, 2016
Licensee / Titulaire de permis :	CVH (No.6) GP Inc. as general partner of CVH (No.6) LP c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angela Rodrigues

To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_365194_0028, CO #005;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

In order to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c), the licensee shall ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair by implementing the following processes:

1. The licensee shall ensure that staff from all departments document and report any needed repairs to maintenance personnel in a timely manner.

2. The licensee shall ensure that audits are conducted at least monthly to all areas accessible to residents in relation to the home's furnishings and equipment being kept clean, sanitary, safe and in a good state of repair.

3. Corrective action plan must be taken by the licensee to address any deficiencies identified by the audits or reported by staff.

4. The licensee shall ensure that the maintenance program is organized to allow for the ongoing routine, preventative and remedial maintenance needs of the home while focussing on addressing this compliance order.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and

in a good state of repair.

As a result of the Resident Quality inspection (RQI) #2015_365194_0028 conducted in November 2015, the licensee was served with a Compliance Order (#005) on January 31, 2016 with an initial compliance date of April 30, 2016. The licensee requested an extension to July 31, 2016 which was agreed upon. The licensee was ordered to ensure that a monitoring process is in place to assess the effectiveness of the housekeeping and maintenance practices in the home. The monitoring process will include a method:
-to ensure that the "deep cleaning policies and practices for the home are implemented and complied with.
-to ensure that re-education is provided, to all departments related to the process for "PM Works", which is the electronic Maintenance requisitions used in the home
-to ensure that the ESM is conducting weekly audits related the home furnishings and equipment being kept clean, sanitary, safe and in a good state of repair.
-Monthly analysis of all PM works received, is completed to identify and address any deficiencies.

During this follow up inspection, the following observations were made, during the period of October 4-6, 2016:

Linden unit:
- TV Lounge area: scraped paint with water damage to window sill with wood exposed; damaged flooring (gouged and cracked with black marks noted) around the middle of the TV lounge area.
- Tub/Shower room: Lower wall damage to wall tiles at corners in three areas;
- In an identified resident's room: ripped laminate flooring in bathroom (about 10 cm).
- In an identified resident's room: gap between floor and base board with dirt accumulating; new white tiles (3 tiles) installed with no grout; space visible between tiles; broken 2 tiles next to vanity with missing pieces exposing the under surface.
- In an identified resident's room: ripped laminate flooring next to toilet base exposing the under surface; broken tile with missing piece next to window exposing the under surface (corner bead);
- In an identified resident's room: noted missing base board at corner next to bathroom door frame exposing a rusted corner bead.

- In an identified resident's room: scraped paint of lower wall above baseboard.

Birch unit:
- In an identified resident's room: scraped paint of lower wall; dark blackish brown staining surrounding base of toilet and surrounding flooring.
- In an identified resident's room: baseboard is lifting at lower corner next bath room exposing the under surface (corner bead).
- In an identified resident's room: lower door frame is chipped.
- In an identified resident's room: the covering of the lower door of the room is loose and chipped creating sharp edges. Lower door frame guard is chipped with sharp edges noted. Scraped paint of lower bathroom door; the bathroom does not close properly; corners of the door are chipped with wood exposed.
- Dry wall damage to lower wall in hallway across from an identified resident's room.
- Water damage/scraped paint with wood exposed of window sill in hallway next to an identified resident's room.
- In two identified residents' rooms – damage to lower door frame guard.
- Damage to lower wall at corners at patio door with rusted corner bead exposed in Birch TV lounge/activity room.

Maple unit:
- Dry wall damage to corner (mid wall) exposing corner bead next to an identified resident's room.
- Dry wall damage to wall corners at entrance of two identified residents' rooms.
- Scraped paint of lower bathroom door of a resident room; Brown stains with small holes on floor from a previously installed commode chair in bathroom.
- Tub room for Maple and Birch units - brown staining on the floor in tub area; gap between floor and wall at entrance of shower area exposing the under surface with dirt accumulating; damaged cover of the light switch; brown stain around toilet base in shower area; missing corner guard of short wall in toilet area; lower wall covering is lifting above baseboard; missing piece of baseboard at entrance of shower area exposing the under surface.
- Brown stains on floor in hallway of Maple unit at entrance of main dining room.

Pine unit:
- Missing hand rail (3 meters long) with 4 holes in dry wall at entrance of Pine unit.
- Scraped paint of lower walls (gouged) above baseboard; chipped lower wooden frame at entrance of Pine TV lounge;

- Tub/Bathing area: Drywall damage to lower wall in toilet area exposing corner bead that was noticed dented inwards; brownish/rust like stain around toilet base; Brown/rust stains around shower/tub; damaged lower corner at sitting/tub shower area exposing drywall and rusted corner bead; damaged wall at corners exposing damaged corner beads at tub room entrance; dry wall damage to lower wall between tub room and shower room.
- Scrapped lower wall next to bathroom door of a resident's room.
- Damage to dry wall in hallway with a hole in dry wall about 10x10 cm behind hand railing next to an identified resident's room.

Aspen unit:
- Spa room: broken multiple tiles (lower row) in tub room with gap noted between floor and tile walls (wall with windows); unfinished dry wall repair at entrance of Spa room (not painted); damage to lower wall at baseboard between tub room and shower room; Damage to lower wall at baseboard at entrance of spa room exposing a dented corner bead; Scraped paint of lower door of spa room; dry wall damage to lower wall in hallway at storage door next to Aspen spa room.
- In two identified residents' rooms; door guard / plastic covering of lower wall is loose and lifting creating sharp corners. Missing lower door plastic covering of two residents' rooms (under surface of brown glue is exposed);
- Damage to corner at door frame of the dining room exposing corner bead of lower and mid wall.

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contractors to finish needed repairs; also staff are encouraged to input all needed repairs using the PM works.

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The compliance order was served on January 31, 2016 with a compliance date extended until July 31, 2016 required weekly audits and monthly analysis to be completed.
Review of the audits provided to inspector indicated that audits were not completed during the months of April and July 2016 and the audits provided were not completed weekly as required by the compliance order and there were no audits completed for common areas. The resident room sanitation and room repair audits were completed on the following dates during the period of January 31, 2016 to July 31, 2016:
Feb 22, 25, 26; March 8, 11, 17; May 16; June 15 and 21, 2016.

On October 06, 2016 interview with the Administrator and and the ESS both indicated to the inspector that issues identified requiring repair (damaged walls in SPA room in Pine unit) was not communicated to maintenance staff through the PM Works software; also not all issues identified by inspector were reported in PM works. The Administrator further indicated that she had no evidence that monthly analysis was completed as required by the order and that her expectation was that the former Environmental Services Manager (ESM) but was unable to provide any documentation.

The decision to re issue the compliance order was based on the widespread deficiencies related to the home, furnishings and equipment not being maintained in a safe condition and in a good state of repair identified during this inspection and the licensee's failure to comply with the requirements of the previous compliance order issued in January 2016 under inspection

#2015_365194_0028. (570)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2017

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

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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

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

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

Issued on this 25th day of November, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sami Jarour

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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347 rue Preston bureau 420
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 25, 2016	2016_327570_0022	028986-16	Complaint

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 04-07, 2016 and October 11, 2016

Compliant inspection Log #028986-16 related to an allegation of abuse.

The following were inspected during the course of this Complaint Inspection:
Critical Incident Logs:
Intake Log #028873-16: Related to an allegation of abuse.
Intake Log #028980-16: Related to an allegation of abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, the licensee`s Regional Director, Director of Care (DOC), Residents, Registered Nurse (RN), Resident Care Area Manager (RCAM), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT), MDS-RAI Coordinator and Family member.

During the course of this inspection, the inspector toured the home, observed staff to resident interactions and provision of care; reviewed clinical health records of identified resident, the licensee's investigation notes and relevant policies.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Related to Log #028986-16

On a specified date, the Ministry of Health and Long-Term Care received a concern related to resident #001. The resident was using a tilt wheelchair and the resident was supposed to be in the tilt position when sitting in wheelchair. On several occasions when visiting, the resident was not observed in the tilt position while seated in the wheelchair and the resident was at risk for falls.

Inspector #570 reviewed the clinical records for resident #001, which indicated the resident was admitted to the home on a specified date with multiple diagnoses including cognitive decline. The resident was identified as a high risk for falls related to poor balance secondary to specified medical conditions and tendency to get up from bed or wheelchair.

On October 05, 2016 at 1035 hours the inspector observed resident #001 sitting in wheelchair (not tilted) against the wall in the hallway across from nursing station of an identified unit until taken to lunch. The resident was observed by the inspector to be sleeping and was not checked upon by staff during the observation period.

On October 06, 2016 at 1015 hours, resident #001 was observed by the inspector sitting in wheelchair (not tilted) in the hallway across from nursing station of an identified unit from 0930 hours; the resident was awake and calm.

The current plan of care for resident #001 reviewed by the inspector on October 6, 2016 indicated under Personal Assistance Service Devices (PASDs): Family requested to have wheelchair tilted when resident is seated in the chair; PSW to ensure wheelchair was tilted when the resident is up in wheelchair to ensure that the resident is positioned properly and comfortable.

During interviews with inspector #570 on October 6 and 11, 2016 with PSWs #110, 115 and 116, it was indicated that resident #001's wheelchair was not tilted all the time when the resident was sitting in the wheelchair; the wheelchair was to be tilted when the resident was sleeping and restless or trying to get up.

On October 11, 2016 at 1000 hours, the inspector observed resident #001 sleeping while sitting in the wheelchair (not tilted) in front of the nursing station. RPN #122 indicated to the inspector that the resident was supposed to be tilted as per care plan on Point Click Care (PCC) electronic documentation system; and because the resident was sleeping,

the wheelchair should have been tilted.

The care set out in the plan of care related to tilting the wheelchair when used by resident #001 was not provided as specified in the current plan of care.

A compliance order was issued under inspection # 2016_327570_0014 related to s. 6. Plan of care, with a compliance date of October 31, 2016. Therefore this noncompliance is issued as a written notification (WN). [s. 6. (7)]

Issued on this 7th day of December, 2016

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

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

Ministère de la Santé et des Soins de longue durée

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

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

Division des foyers de soins de longue durée
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 3, 2017	2016_360111_0038	009275-14	Complaint

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 6 & 7, 2016

A complaint inspection related to low lighting levels was completed.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Environmental Services Supervisor (ESS), and representative from the contracted lighting company.

During the course of the inspection, the inspector toured the home and measured lighting levels: in corridors, resident rooms, resident bathrooms, lounges, nursing stations, tub and shower rooms.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee has failed to ensure that the lighting requirements set out in the lighting table were maintained. The home was built before 2009 so all other homes applied: Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout, All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout, In all other areas of the home - Minimum levels of 215.28 lux & each drug cabinet - Minimum levels of 1,076.39 lux,
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux.

The long term care home was built prior to 2009 and therefore the section of the lighting

table that was applied is titled "all other homes". A hand held digital light meter was used (Amprobe LM-120, accurate to +/- 5%) to measure the lux in various locations in the home. The meter was held a standard 30 inches above and parallel to the floor. All lights were turned on at the time and allowed to warm up. All available doors and bedroom window coverings were closed, in effort to reduce the influence of natural light. When light levels were measured in semi-private or ward resident bedrooms, the privacy curtains between each bed was drawn, to further reduce the influence of natural light in the area of the entrance and around each bed. A sample of resident rooms were measured as all rooms contained same lighting fixtures.

The following areas did not meet the minimum lighting requirement:
The lighting levels in the hallways on Linden, Birch, Maple and Pine unit were 30-40 % of the required lighting levels of 215.23 lux in between the ballast light fixtures which were spaced approximately eight feet apart.
The lighting level in the corridor in front of the main dining room (at entrance of the home) was 75% of the required lighting levels of 215 lux. This area is also used by nursing staff to place the medication carts.

The lighting levels in residents rooms on Linden: L5 (ward), L8 (semi), L16 (semi) ranged from 10- 75 % of the required lighting levels. This excluded the areas at the head of the bed and the resident bathrooms as these areas met the lighting requirements.
The lighting levels on Birch: B6(semi) & B13 (private) ranged from 10- 75 % of the required lighting levels. This excluded the areas at the head of the bed and the resident bathrooms as these areas met the lighting requirements.
Maple and Pine unit resident rooms were not measured but contained the same light fixtures.

Linden nursing station measured 25 % of lighting requirement in front of the nursing desk area and in from of the Resident Care Manager office. Inside the nursing station (where the nursing staff sit to read resident charts, etc.) measured 40-70 % of required lighting levels of 215 lux.

Interview with the Administrator indicated the home had a lighting assessment completed and the home had been provided corporate approval to begin completing the lighting upgrade starting in March 2017. [s. 18.]

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 the lighting requirements set out in the lighting table are maintained: (homes built before 2009) - All corridors and all other areas of the home: Minimum levels of 215.28 lux continuous consistent lighting throughout. At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux., to be implemented voluntarily.

Issued on this 3rd day of January, 2017

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

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

Ottawa Service Area Office
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Bureau régional de services d'Ottawa
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Télécopieur: (613) 569-9670

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
Feb 08, 2017;	2016_199626_0032 (A1)	027722-16, 027730-16, 027734-16	Follow up

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

DENISE BROWN (626) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

On February 7, 2017 the home's Administrator requested a change in compliance date for order #001. A new compliance date was granted for March 31, 2017.

Issued on this 8 day of February 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

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Long-Term Care Inspections Branch

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 08, 2017;	2016_199626_0032 (A1)	027722-16, 027730-16, 027734-16	Follow up

Licensee/Titulaire de permis

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

DENISE BROWN (626) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 14, 15, 16, 19, 20, 21, 22, 23 and 28, 2016

Follow-up Intake Logs:

Intake Log #027722-16: CO #001 related to plan of care

Intake Log #027730-16: CO #002 related to medication administration

Intake Log #027734-16: CO #003 related to medication administration

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (DOC), Resident Care Area Managers (RCAM), Register Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Clinical Consultant Pharmacist, Physiotherapy Assistants, Educator and residents.

During the inspection the inspector toured the resident home areas, observed staff to resident provision of care and medication administration. The inspector reviewed residents' health records and applicable policies.

The following policies were reviewed:

Falls Management, Medication Management, Medication Incident and Reporting, High Alert Medications and Responsive Behaviours.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Hospitalization and Change in Condition

Medication

Responsive Behaviours

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **1 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
O.Reg 79/10 s. 131. (1)	CO #002	2016_327570_0014	626
LTCHA, 2007 s. 6.	WN	2016_327570_0014	626
LTCHA, 2007 s. 6.	CO #001	2016_327570_0014	626

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On December 14, 2016, an inspection was conducted in follow-up inspection to determine compliance to Compliance Orders (CO) #001, CO #002 and CO #003. These three orders were related to a previous inspection in 2016 and had a specified date for re-inspection. The current inspection revealed, that the home was compliant in meeting the requirements of CO #001, CO #002 and was compliant with some of the requirements of CO #003 which is indicated as follows:

- Conducting Electronic Medication Record (eMar) daily audit for 15 consecutive days involving 10 percent of the six Resident Home Areas (RHA) to assess accuracy;

- Ensure that the eMar audit process includes a visual verification of all key elements of the medication administration process, including but not limited to ensuring that the right resident is receiving the right medications, at the right dose, using the right route at the specified time.

- Review the current medication administration routines to ensure appropriate support systems are in place when employing new or casual nurses or when the usual RN/RPN deployment pattern is altered.

In the same inspection, related to CO #003, it was determined that the home was non-compliant with the following stipulation of the order:

- Take effective corrective actions when registered nursing staff are not administering medications in line with legislative requirements, established practice standards, policies or procedures.

Compliance Order #003 required that the home take effective corrective actions when registered nursing staff are not administering medication in line with legislative
requirements, established practice standards, policies or procedures and to achieve compliance by a specified date in 2016. A review of the documentation after the specified compliance date, indicated that this was not consistently performed.

A review of two separate documentations pertaining to resident #005, indicated that the first incident occurred on two separate specified dates and found that a specified medication was omitted for a period of three days. Based on the records reviewed, there was no evidence of corrective actions.

During an interview, the DOC could not recall discussing this incident with the registered staff members involved in the incidents.

A review of the documentation pertaining to resident #011, who was admitted on a specified date in 2016, indicated that the resident did not receive medications until the following day. The resident did not receive four medications as information was not properly entered into Point Click Care and was required to confirm the medications which were pending in the system. There was documentation by the Pharmacist pertaining to the cause of the incident and suggestions for nursing but there was no evidence that this was communicated to the registered staff.

In an interview, the DOC could not recall discussing this incident with the registered staff members involved in the incident.

A review of the documentation involving resident #005 and resident #011 on two separate dates, found no corrective action following the incidents. In an interview with the inspector on December 20, 2016, the DOC did not recall speaking to the registered staff regarding a corrective action following the incidents. There was no indication that the residents experienced any adverse reactions as a result of the medication incidents.

During separate interviews on December 20, 2016, RPN #100, #107 and #108 who were not involved in these medication incidents and were not aware of corrective actions related to any incidents, all indicated that they were aware of the process. Registered Practical Nurses #100, #107 and #108 in their separate interviews on a specified date indicated, that following staff involvement in a medication incident, the incident would be reported to the DOC and staff disciplined or retrained.

Pharmacy Consultant #106 in an interview on December 20, 2016, indicated that the incident report form was revised and the new forms did not contain a response time. Subsequently, pharmacy had not responded to the home in a timely manner with corrective actions for medication incidents in order for the DOC to act on. This problem was discovered in the monthly meeting and was corrected. In the same interview the Pharmacy Consultant #106, indicated that medication incidents and corrective actions are documented on the Incident Report Summary and reviewed in the Medication Management Meetings held at the home on a monthly basis.

In another interview on December 28, 2016, the Administrator indicated that it was

the understanding that the DOC had followed-up with corrective actions when there were medication incidents. In the same interview, the Administrator indicated that it is the expectation in the home that corrective action be taken when there is a medication incident and that this information should be communicated to the staff involved and documented.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber and corrective actions were not taken when registered staff did not administer medications as prescribed. [s. 131. (2)]

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

Review of the licensee`s Medication Management policy RC-06-05-07, updated June 2016, outlines the practice requirements under the following sections:

Required Documents
b. MAR/eMAR-Paper or electronic format to be used to document all medications given to a resident.

Policy
The medication administration process will comply with all applicable professional standards of practice, accreditation standards, provincial legislation and pharmacy policies to ensure safe, effective and ethical administration of medications.

Procedures
5. Scheduled medications will be administered according to standard medication administration times.
Medication should be given with in the recommended time frame, 60 minutes prior to and 60 minutes after the scheduled administration time.
10. Medications will be administered following the 8 rights of medication administration: Right resident; Right drug; Right dose; Right time; Right route (including need for medication to be crushed); Right reason; Right response; Right documentation.

The Medication Administration Audit Report was generated the eMAR indicate, the medication scheduled administration time, the actual time that the medication was administered and the time that it was documented by the nurse.

Related to resident #008

A review of the Medication Administration Audit Report of a specified month in 2016, identified that resident #008's three scheduled medications were administered in the morning. The three medications were administered greater than one hour of the scheduled medication administration time on six separate days. One of the three medications was schedule to be administered more than once a day and was administered again at noon on each of these six days, at intervals of fifty minutes to two hours following the morning dose. There was no indication that the resident had experienced any adverse reactions.

The licensee failed to ensure that drugs were administered to residents at the time specified and not greater than 60 minutes after the scheduled administration time, in accordance to the licensee's Medication Management policy RC-06-05-07. The licensee has also failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s.131. (2)]

3. Related to resident #005

A review of the Medication Administration Audit Report of a specified month in 2016, identified that resident #005's nine scheduled medications were administered in the morning. The nine medications were administered greater than one hour of the scheduled medication administration time on four separate days. One of the nine medications was schedule to be administered more than once a day and was administered again at noon on each of these four days at intervals of one to three hours following the morning dose. There was no indication that the resident had experienced any adverse reactions.

The licensee failed to ensure that drugs were administered to residents at the time specified and not greater than 60 minutes after the scheduled administration time, in accordance to the licensee's Medication Management policy RC-06-05-07. The licensee has also failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s.131. (2)]

4. Related to resident #007

A review of the Medication Administration Audit Report of a specified month in 2016, identified that resident #007's six scheduled medications were administered in the morning. The six medications were administered greater than one hour of the scheduled medication administration time on four separate days. One of the six medications was schedule to be administered more than once a day and was administered again at noon on each of these four days at intervals of two to three hours following the morning dose. There was no indication that the resident had experienced any adverse reactions.

The licensee failed to ensure that drugs were administered to residents at the time specified and not greater than 60 minutes after the scheduled administration time, in accordance to the licensee's Medication Management policy RC-06-05-07. The licensee has also failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s.131. (2)]

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 8 day of February 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston, bureau 420
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : DENISE BROWN (626) - (A1)

Inspection No. / No de l'inspection : 2016_199626_0032 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 027722-16, 027730-16, 027734-16 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Feb 08, 2017;(A1)

Licensee / Titulaire de permis : CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD : Orchard Villa
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Angela Rodrigues

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To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_327570_0014, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

1. Immediately upon being served with this Compliance Order and for 15 consecutive days after that to conduct a 15 day audit of at least 10 percent of the electronic medication records (E-Mar) currently in use in each of the six Resident Home Areas (RHA) to review the E-MAR and assess the practice of medication administration at the time specified and,

2. Develop and implement a plan to ensure that medications are administered at the specified time and,

3. Educate all registered nursing staff and agency registered nursing staff about the licensee Policy #RC-06-05-07 Medication Management in a formal education session, and evaluate staff knowledge of the policy following the session, which should include understanding of the policy's requirement to administer medication within 60 minutes of the scheduled time of the medication.

4. Take immediate effective corrective actions as it pertains to medication incidents, when registered nursing staff are not administering medication in line with legislative requirements, established practice standards, policies or procedures.

5. Extendicare Assist must immediately provide nursing leadership and play an active role in supporting the home in implementing effective response in the analysis of the medication audits, staff education related to medication administration, corrective action as pertains to medication administration practices, including and not limited to medication incidents.

Grounds / Motifs :

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

On December 14, 2016, an inspection was conducted in follow-up inspection to determine compliance to Compliance Orders (CO) #001, CO #002 and CO #003. These three orders were related to a previous inspection in 2016 and had a specified date for re-inspection. The current inspection revealed, that the home was compliant in meeting the requirements of CO #001, CO #002 and was compliant with some of the requirements of CO #003 which is indicated as follows:

- Conducting Electronic Medication Record (eMar) daily audit for 15 consecutive days involving 10 percent of the six Resident Home Areas (RHA) to assess accuracy;

- Ensure that the eMar audit process includes a visual verification of all key elements of the medication administration process, including but not limited to ensuring that the right resident is receiving the right medications, at the right dose, using the right route at the specified time.

- Review the current medication administration routines to ensure appropriate support systems are in place when employing new or casual nurses or when the usual RN/RPN deployment pattern is altered.

In the same inspection, related to CO #003, it was determined that the home was non-compliant with the following stipulation of the order:

- Take effective corrective actions when registered nursing staff are not administering medications in line with legislative requirements, established practice standards, policies or procedures.

Compliance Order #003 required that the home take effective corrective actions when registered nursing staff are not administering medication in line with legislative requirements, established practice standards, policies or procedures and to achieve compliance by a specified date in 2016. A review of the documentation after the specified compliance date, indicated that this was not consistently performed.

A review of two separate documentations pertaining to resident #005, indicated that the first incident occurred on two separate specified dates and found that a specified medication was omitted for a period of three days. Based on the records reviewed, there was no evidence of corrective actions.

During an interview the DOC could not recall discussing this incident with the registered staff members involved in the incidents.

A review of the documentation pertaining to resident #011, who was admitted on a specified date in 2016, indicated that the resident did not receive medications until the following day. The resident did not receive four medications as information was

not properly entered into Point Click Care and was required to confirm the medications which were pending in the system. There was documentation by the pharmacist pertaining to the cause of the incident and suggestions for nursing but there was no evidence that this was communicated to the registered staff.

In an interview, the DOC could not recall discussing this incident with the registered staff members involved in the incident.

A review of the documentation involving resident #005 and resident #011 on two separate dates, found no corrective action following the incidents. In an interview with the inspector on December 20, 2016, the DOC did not recall speaking to the registered staff regarding a corrective action following the incidents. There was no indication that the residents experienced any adverse reactions as a result of the medication incidents.

During separate interviews on December 20, 2016, RPN #100, #107 and #108 who were not involved in these medication incidents and were not aware of corrective actions related to any incidents, all indicated that they were aware of the process. Registered Practical Nurses #100, #107 and #108 in their separate interviews on a specified date indicated, that following staff involvement in a medication incident, the incident would be reported to the DOC and staff disciplined or retrained.

Pharmacy Consultant #106 in an interview on December 20, 2016, indicated that the incident report form was revised and the new forms did not contain a response time. Subsequently, pharmacy had not responded to the home in a timely manner with corrective actions for medication incidents in order for the DOC to act on. This problem was discovered in the monthly meeting and was corrected. In the same interview the Pharmacy Consultant #106 indicated that medication incidents and corrective actions are documented on the Incident Report Summary and reviewed in the Medication Management Meetings held at the home on a monthly basis.

In another interview on December 20, 2016, the Administrator indicated that it was the understanding that the DOC had followed-up with corrective actions when there were medication incidents. In the same interview, the Administrator indicated that it is the expectation in the home that corrective action be taken when there is a medication incident and that this information should be communicated to the staff involved and documented.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber and corrective actions were not taken when registered staff did not administer medications as prescribed. [s. 131. (2)] (626)

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

Review of the licensee`s Medication Management policy RC-06-05-07, updated June 2016, outlines the practice requirements under the following sections:

Required Documents
b. MAR/eMAR-Paper or electronic format to be used to document all medications given to a resident.

Policy
The medication administration process will comply with all applicable professional standards of practice, accreditation standards, provincial legislation and pharmacy policies to ensure safe, effective and ethical administration of medications.

Procedures
5. Scheduled medications will be administered according to standard medication administration times.
Medication should be given with in the recommended time frame, 60 minutes prior to and 60 minutes after the scheduled administration time.
10. Medications will be administered following the 8 rights of medication administration: Right resident; Right drug; Right dose; Right time; Right route (including need for medication to be crushed); Right reason; Right response; Right documentation.

The Medication Administration Audit Report was generated the eMAR indicate, the medication scheduled administration time, the actual time that the medication was administered and the time that it was documented by the nurse.

Related to resident #008

A review of the Medication Administration Audit Report of a specified month in 2016, identified that resident #008's three scheduled medications were administered in the morning. The three medications were administered greater than one hour of the scheduled medication administration time on six separate days. One of the three medications was schedule to be administered more than once a day and was administered again at noon on each of these six days at intervals of fifty minutes to two hours following the morning dose. There was no indication that the resident had experienced any adverse reactions.

The licensee failed to ensure that drugs were administered to residents at the time specified and not greater than 60 minutes after the scheduled administration time, in accordance to the licensee's Medication Management policy RC-06-05-07. The licensee has also failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s.131. (2)] (626)

3. Related to resident #005

A review of the Medication Administration Audit Report of a specified month in 2016, identified that resident #005's nine scheduled medications were administered in the morning. The nine medications were administered greater than one hour of the scheduled medication administration time on four separate days. One of the nine medications was schedule to be administered more than once a day and was administered again at noon on each of these four days, at intervals of one to three hours following the morning dose. There was no indication that the resident had experienced any adverse reactions.

The licensee failed to ensure that drugs were administered to residents at the time specified and not greater than 60 minutes after the scheduled administration time, in accordance to the licensee's Medication Management policy RC-06-05-07. The licensee has also failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s.131. (2)] (626)

4. Related to resident #007

A review of the Medication Administration Audit Report of a specified month in 2016, identified that resident #007's six scheduled medications were administered in the morning. The six medications were administered greater than one hour of the scheduled medication administration time on four separate days. One of the six medications was schedule to be administered more than once a day and was administered again at noon on each of these four days at intervals of two to three hours following the morning dose. There was no indication that the resident had experienced any adverse reactions.

The licensee failed to ensure that drugs were administered to residents at the time specified and not greater than 60 minutes after the scheduled administration time, in accordance to the licensee's Medication Management policy RC-06-05-07. The licensee has also failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s.131. (2)]

This order is being reissued for the fourth time under s. 131 (2) because the licensee was previously ordered to develop and implement a monitoring process to ensure that all medications were administered to all residents in accordance to the direction for use , and as specified by the prescriber. Compliance Order #003 was issued under LTCHA 2017, s.131 (2) Administration of Drugs during inspection #2015_365194_0028 with compliance date of February 29, 2016 and was reissued during inspection #2016_360111_0009 with compliance date of May 26, 2016. This Compliance Order was reissued during inspection #2016_327570_0014 with compliance date of October 31, 2016, which also requires corrective action when registered nursing staff are not administering medications in line with legislative requirements, established practice standards, policies or procedures. This history of repeated non-compliance, along with the scope and risk associated with the noted medication administration practices in the home were considered when the decision to issue this order was made. This non-compliance is also being referred to the Director for further action by the Director. (626)

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

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

Mar 31, 2017(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
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 8 day of February 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DENISE BROWN

Service Area Office /
Bureau régional de services : Ottawa

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
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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
Feb 17, 2017;	2016_327570_0021 (A1)	002610-16	Follow up

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

SAMI JAROUR (570) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested an extension of the compliance date to April 30, 2017.

Issued on this 17 day of February 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 17, 2017;	2016_327570_0021 (A1)	002610-16	Follow up

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

SAMI JAROUR (570) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 04-07, 2016 and October 11, 2016

Follow up inspection Log #002610-16 related to compliance order #005 issued under inspection #2015_365194_0028 regarding the home, furnishings and equipment not maintained in a safe condition and in a good state of repair with a compliance date of July 31, 2016.

During the course of the inspection, the inspector(s) spoke with Administrator, the licensee`s Regional Director, Director of Care (DOC), Residents, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nurse Administrative Assistant, Environmental Services Supervisor (ESS), Housekeeping staff and the Pharmacist.

During the course of this inspection, the inspector toured the home, observed staff to residents interactions and provision of care; reviewed clinical health records of identified resident, relevant policies, housekeeping and maintenance audit records, staff educational records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Medication

Safe and Secure Home

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

3 WN(s)
1 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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 failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

As a result of the Resident Quality inspection (RQI) #2015_365194_0028 conducted in November 2015, the licensee was served with a Compliance Order (#005) on January 31, 2016 with an initial compliance date of April 30, 2016. The licensee requested an extension to July 31, 2016 which was agreed upon. The licensee was ordered to ensure that a monitoring process is in place to assess the effectiveness of the housekeeping and maintenance practices in the home. The monitoring process will include a method:
-to ensure that the "deep cleaning policies and practices for the home are implemented and complied with.
-to ensure that re-education is provided, to all departments related to the process for "PM Works", which is the electronic Maintenance requisitions used in the home
-to ensure that the ESM is conducting weekly audits related the home furnishings and equipment being kept clean, sanitary, safe and in a good state of repair.
-Monthly analysis of all PM works received, is completed to identify and address any deficiencies.

During this follow up inspection, the following observations were made, during the period of October 4-6, 2016:

Linden unit:
- TV Lounge area: scraped paint with water damage to window sill with wood exposed; damaged flooring (gouged and cracked with black marks noted) around

the middle of the TV lounge area.
- Tub/Shower room: Lower wall damage to wall tiles at corners in three areas;
- In an identified resident's room: ripped laminate flooring in bathroom (about 10 cm).
- In an identified resident's room: gap between floor and base board with dirt accumulating; new white tiles (3 tiles) installed with no grout; space visible between tiles; broken 2 tiles next to vanity with missing pieces exposing the under surface.
- In an identified resident's room: ripped laminate flooring next to toilet base exposing the under surface; broken tile with missing piece next to window exposing the under surface (corner bead);
- In an identified resident's room: noted missing base board at corner next to bathroom door frame exposing a rusted corner bead.
- In an identified resident's room: scraped paint of lower wall above baseboard.

Birch unit:
- In an identified resident's room: scraped paint of lower wall; dark blackish brown staining surrounding base of toilet and surrounding flooring.
- In an identified resident's room: baseboard is lifting at lower corner next bath room exposing the under surface (corner bead).
- In an identified resident's room: lower door frame is chipped.
- In an identified resident's room: the covering of the lower door of the room is loose and chipped creating sharp edges. Lower door frame guard is chipped with sharp edges noted. Scraped paint of lower bathroom door; the bathroom does not close properly; corners of the door are chipped with wood exposed.
- Dry wall damage to lower wall in hallway across from an identified resident's room.
- Water damage/scraped paint with wood exposed of window sill in hallway next to an identified resident's room.
- In two identified residents' rooms – damage to lower door frame guard.
- Damage to lower wall at corners at patio door with rusted corner bead exposed in Birch TV lounge/activity room.

Maple unit:
- Dry wall damage to corner (mid wall) exposing corner bead next to an identified resident's room.
- Dry wall damage to wall corners at entrance of two identified residents' rooms.
- Scraped paint of lower bathroom door of a resident room; Brown stains with small holes on floor from a previously installed commode chair in bathroom.
- Tub room for Maple and Birch units - brown staining on the floor in tub area; gap

between floor and wall at entrance of shower area exposing the under surface with dirt accumulating; damaged cover of the light switch; brown stain around toilet base in shower area; missing corner guard of short wall in toilet area; lower wall covering is lifting above baseboard; missing piece of baseboard at entrance of shower area exposing the under surface.
- Brown stains on floor in hallway of Maple unit at entrance of main dining room.

Pine unit:
- Missing hand rail (3 meters long) with 4 holes in dry wall at entrance of Pine unit.
- Scraped paint of lower walls (gouged) above baseboard; chipped lower wooden frame at entrance of Pine TV lounge;
- Tub/Bathing area: Drywall damage to lower wall in toilet area exposing corner bead that was noticed dented inwards; brownish/rust like stain around toilet base; Brown/rust stains around shower/tub; damaged lower corner at sitting/tub shower area exposing drywall and rusted corner bead; damaged wall at corners exposing damaged corner beads at tub room entrance; dry wall damage to lower wall between tub room and shower room.
- Scrapped lower wall next to bathroom door of a resident's room.
- Damage to dry wall in hallway with a hole in dry wall about 10x10 cm behind hand railing next to an identified resident's room.
Aspen unit:
- Spa room: broken multiple tiles (lower row) in tub room with gap noted between floor and tile walls (wall with windows); unfinished dry wall repair at entrance of Spa room (not painted); damage to lower wall at baseboard between tub room and shower room; Damage to lower wall at baseboard at entrance of spa room exposing a dented corner bead; Scraped paint of lower door of spa room; dry wall damage to lower wall in hallway at storage door next to Aspen spa room.
- In two identified residents' rooms; door guard / plastic covering of lower wall is loose and lifting creating sharp corners. Missing lower door plastic covering of two residents' rooms (under surface of brown glue is exposed);
- Damage to corner at door frame of the dining room exposing corner bead of lower and mid wall.

On October 05, 2016 the Environmental Services Supervisor (ESS) indicated to the inspector that maintenance staff become aware of areas in need of repair by accessing PM Works (electronic maintenance requisition software) several times a day for repair with anything resident related or high risk area will be fixed within 24 hours.

On October 05, 2016, inspector #570 interviewed the Administrator and the Extendicare Regional Director. The Administrator indicated the preventative maintenance program of the home is included in the PM Works for day to day maintenance schedule and also includes what was scheduled weekly or monthly for preventative maintenance. The Regional Director indicated that the focus was on repairing the deficiencies identified in the MOHLTC inspection report issued in January 2016 and the repairs to those deficiencies were completed. The Administrator further indicated that it is the expectation that all repairs were to be identified and completed; for that a maintenance supervisor was hired in August 2016 so that repairs can be done by maintenance staff if possible and to avoid bringing in contractors unless needed; it was taking too much time for contractors to finish needed repairs; also staff are encouraged to input all needed repairs using the PM works.

On October 05, 2016, during a tour of the Spa room in Pine unit and lounge area in Linden unit with the Regional Director, Administrator and Environmental Services Supervisor (ESS) all indicated that they were not aware of the Pine unit and Linden unit. The regional director indicated to the inspector that the spa room in Pine unit was recently repaired and the damage noted to walls was new. The ESS confirmed to the inspector that none of the damages noted in the Pine spa room and Linden TV lounge were reported to maintenance staff by using the PM Works software. The ESS further indicated that the expectation of the home is that staff will continue to use PM works to communicate needed repairs to the maintenance staff.

The compliance order was served on January 31, 2016 with a compliance date extended until July 31, 2016 required weekly audits and monthly analysis to be completed.
Review of the audits provided to inspector indicated that audits were not completed during the months of April and July 2016 and the audits provided were not completed weekly as required by the compliance order and there were no audits completed for common areas. The resident room sanitation and room repair audits were completed on the following dates during the period of January 31, 2016 to July 31, 2016:
Feb 22, 25, 26; March 8, 11, 17; May 16; June 15 and 21, 2016.

On October 06, 2016 interview with the Administrator and and the ESS both indicated to the inspector that issues identified requiring repair (damaged walls in SPA room in Pine unit) was not communicated to maintenance staff through the

PM Works software; also not all issues identified by inspector were reported in PM works. The Administrator further indicated that she had no evidence that monthly analysis was completed as required by the order and that her expectation was that the former Environmental Services Manager (ESM) but was unable to provide any documentation.

The decision to re issue the compliance order was based on the widespread deficiencies related to the home , furnishings and equipment not being maintained in a safe condition and in a good state of repair identified during this inspection and the licensee's failure to comply with the requirements of the previous compliance order issued in January 2016 under inspection #2015_365194_0028. [s. 15. (2) (c)]

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. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 122.(1), by not ensuring that no drug is acquired, received or stored by or in the home or kept by a resident unless the drug:
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply, and
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario.

Related to resident #002

On October 11, 2016 at about 1430 hours the following was witnessed by inspector #570:
Resident #002 came to the nursing station on an identified unit and handed a box of prescription drug (controlled substance) to RPN #112. The box was noted to be sealed. Resident #002 told RPN #112 that PSW #113 gave the box to him/her and that he/she was surprised that the box was delivered to him/her.

On October 11, 2016, RPN #112 indicated to the inspector that staff #114 gave the box of a prescription drug (controlled substance) to PSW #113 who gave it to resident #002; later RPN #112 indicated he/she phoned the pharmacy who indicated that the box was sent to the home by a taxi driver with instructions to be delivered to the unit's Charge Nurse. RPN #112 indicated that he/she called the pharmacy for the prescription drug (controlled substance) today and this package should have been delivered to the RPN and if the RPN was not available it should have been delivered to one of the Residents Care Area Managers (RCAM). RPN #112 indicated to the inspector that the package was sealed.

On October 11, 2016 at about 1450 hours during an interview with PSW #113, it was indicated to the inspector that at about 1415 hours, Staff #114 gave him/her a package to be delivered to resident #002 and that he/she was not aware of the content of the package.

On October 11, 2016 at about 1500 hours during an interview with resident #002, it was indicated to the inspector that he/she gets the prescription drug (controlled substance) every 3 days and that the medication helps with pain. The resident also indicted that he/she was aware of the content of the package and that he/she was

concerned if the package had fallen into the wrong hands.

On October 11, 2016 at about 1517 hours during an interview with staff #114 it was indicated to the inspector that a gentleman came to the door and delivered a package to him/her and said, no signature was required when asked. Staff #114 indicated to the inspector no awareness that the package included a prescription drug (controlled substance).

On October 11, 2016 at about 1612 hours during an interview with the home's contracted pharmacist, he indicated to the inspector that he was made aware of the prescription drug (controlled substance) box that was not delivered to Registered Nurse and was not signed off by a Registered Nurse. The pharmacist indicated that the expectations were that the taxi driver should have followed instructions and delivered the package to a Registered Nurse and should have gotten a signature; the nurse has to sign for it and add it to the controlled substances count. The Pharmacist indicated to the inspector that those were the instructions given by the pharmacy to the taxi driver; however, those instructions were not followed by the taxi driver.

The licensee failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident when a package of prescription drug (controlled substance) was delivered to non-registered staff at the home and later delivered to resident #002 before the package was secured by RPN #112. [s. 122. (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 there is a process in place and monitored, ensuring that no drug is acquired, received or stored by or in the home or kept by a resident unless the drug:
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply, and
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 14, by not ensuring each resident shower have at least two easily accessible grab bars, one grab bar located on the same wall as the faucet and one grab bar located on the adjacent wall.

On October 04, 2016 during an observation of the bathing areas located at the Pine and Linden units, inspector #570 noted the shower areas in both units did not have a shower grab bar located on the adjacent wall of the faucet.

On October 4, 2016 Personal Support Worker (PSW) #110 indicated to the inspector the shower area in Pine unit was used in the morning to provide showers to residents.

On October 05, 2016 Environmental Services Supervisor (ESS) indicated to the inspector that he was aware that two grab bars are required in shower areas but was not aware that shower grab bars were not installed at the adjacent wall of the faucet in the two identified shower areas. [s. 14.]

Issued on this 17 day of February 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston, bureau 420
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SAMI JAROUR (570) - (A1)

Inspection No. / No de l'inspection : 2016_327570_0021 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 002610-16 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Feb 17, 2017;(A1)

Licensee / Titulaire de permis :
CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD :
Orchard Villa
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Angela Rodrigues

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To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_365194_0028, CO #005;

Pursuant to / Aux termes de :

LTCHA, 2007, 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;

(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and

(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).

Order / Ordre :

In order to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c), the licensee shall ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair by implementing the following processes:

1. The licensee shall ensure that staff from all departments document and report any needed repairs to maintenance personnel in a timely manner.

2. The licensee shall ensure that audits are conducted at least monthly to all areas accessible to residents in relation to the home's furnishings and equipment being kept clean, sanitary, safe and in a good state of repair.

3. Corrective action plan must be taken by the licensee to address any deficiencies identified by the audits or reported by staff.

4. The licensee shall ensure that the maintenance program is organized to allow for the ongoing routine, preventative and remedial maintenance needs of the home while focussing on addressing this compliance order.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

As a result of the Resident Quality inspection (RQI) #2015_365194_0028 conducted in November 2015, the licensee was served with a Compliance Order (#005) on January 31, 2016 with an initial compliance date of April 30, 2016. The licensee requested an extension to July 31, 2016 which was agreed upon. The licensee was ordered to ensure that a monitoring process is in place to assess the effectiveness of the housekeeping and maintenance practices in the home. The monitoring process will include a method:
-to ensure that the "deep cleaning policies and practices for the home are implemented and complied with.
-to ensure that re-education is provided, to all departments related to the process for "PM Works", which is the electronic Maintenance requisitions used in the home
-to ensure that the ESM is conducting weekly audits related the home furnishings and equipment being kept clean, sanitary, safe and in a good state of repair.

-Monthly analysis of all PM works received, is completed to identify and address any deficiencies.

During this follow up inspection, the following observations were made, during the period of October 4-6, 2016:

Linden unit:
- TV Lounge area: scraped paint with water damage to window sill with wood exposed; damaged flooring (gouged and cracked with black marks noted) around the middle of the TV lounge area.
- Tub/Shower room: Lower wall damage to wall tiles at corners in three areas;
- In an identified resident's room: ripped laminate flooring in bathroom (about 10 cm).
- In an identified resident's room: gap between floor and base board with dirt accumulating; new white tiles (3 tiles) installed with no grout; space visible between tiles; broken 2 tiles next to vanity with missing pieces exposing the under surface.
- In an identified resident's room: ripped laminate flooring next to toilet base exposing the under surface; broken tile with missing piece next to window exposing the under surface (corner bead);
- In an identified resident's room: noted missing base board at corner next to bathroom door frame exposing a rusted corner bead.
- In an identified resident's room: scraped paint of lower wall above baseboard.

Birch unit:
- In an identified resident's room: scraped paint of lower wall; dark blackish brown staining surrounding base of toilet and surrounding flooring.
- In an identified resident's room: baseboard is lifting at lower corner next bath room exposing the under surface (corner bead).
- In an identified resident's room: lower door frame is chipped.
- In an identified resident's room: the covering of the lower door of the room is loose and chipped creating sharp edges. Lower door frame guard is chipped with sharp edges noted. Scraped paint of lower bathroom door; the bathroom does not close properly; corners of the door are chipped with wood exposed.
- Dry wall damage to lower wall in hallway across from an identified resident's room.
- Water damage/scraped paint with wood exposed of window sill in hallway next to an identified resident's room.
- In two identified residents' rooms – damage to lower door frame guard.
- Damage to lower wall at corners at patio door with rusted corner bead exposed in Birch TV lounge/activity room.

Maple unit:
- Dry wall damage to corner (mid wall) exposing corner bead next to an identified resident's room.
- Dry wall damage to wall corners at entrance of two identified residents' rooms.
- Scraped paint of lower bathroom door of a resident room; Brown stains with small holes on floor from a previously installed commode chair in bathroom.
- Tub room for Maple and Birch units - brown staining on the floor in tub area; gap between floor and wall at entrance of shower area exposing the under surface with dirt accumulating; damaged cover of the light switch; brown stain around toilet base in shower area; missing corner guard of short wall in toilet area; lower wall covering is lifting above baseboard; missing piece of baseboard at entrance of shower area exposing the under surface.
- Brown stains on floor in hallway of Maple unit at entrance of main dining room.

Pine unit:
- Missing hand rail (3 meters long) with 4 holes in dry wall at entrance of Pine unit.
- Scraped paint of lower walls (gouged) above baseboard; chipped lower wooden frame at entrance of Pine TV lounge;
- Tub/Bathing area: Drywall damage to lower wall in toilet area exposing corner bead that was noticed dented inwards; brownish/rust like stain around toilet base; Brown/rust stains around shower/tub; damaged lower corner at sitting/tub shower area exposing drywall and rusted corner bead; damaged wall at corners exposing damaged corner beads at tub room entrance; dry wall damage to lower wall between tub room and shower room.
- Scrapped lower wall next to bathroom door of a resident's room.
- Damage to dry wall in hallway with a hole in dry wall about 10x10 cm behind hand railing next to an identified resident's room.

Aspen unit:
- Spa room: broken multiple tiles (lower row) in tub room with gap noted between floor and tile walls (wall with windows); unfinished dry wall repair at entrance of Spa room (not painted); damage to lower wall at baseboard between tub room and shower room; Damage to lower wall at baseboard at entrance of spa room exposing a dented corner bead; Scraped paint of lower door of spa room; dry wall damage to lower wall in hallway at storage door next to Aspen spa room.
- In two identified residents' rooms; door guard / plastic covering of lower wall is loose and lifting creating sharp corners. Missing lower door plastic covering of two residents' rooms (under surface of brown glue is exposed);

- Damage to corner at door frame of the dining room exposing corner bead of lower and mid wall.

On October 05, 2016 the Environmental Services Supervisor (ESS) indicated to the inspector that maintenance staff become aware of areas in need of repair by accessing PM Works (electronic maintenance requisition software) several times a day for repair with anything resident related or high risk area will be fixed within 24 hours.

On October 05, 2016, inspector #570 interviewed the Administrator and the Extendicare Regional Director. The Administrator indicated the preventative maintenance program of the home is included in the PM Works for day to day maintenance schedule and also includes what was scheduled weekly or monthly for preventative maintenance. The Regional Director indicated that the focus was on repairing the deficiencies identified in the MOHLTC inspection report issued in January 2016 and the repairs to those deficiencies were completed. The Administrator further indicated that it is the expectation that all repairs were to be identified and completed; for that a maintenance supervisor was hired in August 2016 so that repairs can be done by maintenance staff if possible and to avoid bringing in contractors unless needed; it was taking too much time for contractors to finish needed repairs; also staff are encouraged to input all needed repairs using the PM works.

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weekly as required by the compliance order and there were no audits completed for common areas. The resident room sanitation and room repair audits were completed on the following dates during the period of January 31, 2016 to July 31, 2016: Feb 22, 25, 26; March 8, 11, 17; May 16; June 15 and 21, 2016.

On October 06, 2016 interview with the Administrator and and the ESS both indicated to the inspector that issues identified requiring repair (damaged walls in SPA room in Pine unit) was not communicated to maintenance staff through the PM Works software; also not all issues identified by inspector were reported in PM works. The Administrator further indicated that she had no evidence that monthly analysis was completed as required by the order and that her expectation was that the former Environmental Services Manager (ESM) but was unable to provide any documentation.

The decision to re issue the compliance order was based on the widespread deficiencies related to the home, furnishings and equipment not being maintained in a safe condition and in a good state of repair identified during this inspection and the licensee's failure to comply with the requirements of the previous compliance order issued in January 2016 under inspection #2015_365194_0028. (570)

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

Apr 30, 2017(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
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 17 day of February 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SAMI JAROUR

Service Area Office /
Bureau régional de services : Ottawa

Ministry of Health and Long-Term Care
Long-Term Care Homes Division
Long-Term Inspections Branch

Ministère de la Santé et des Soins de longue durée
Inspection de soins de longue durée
Division des foyers de soins de longue durée

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** X **Public Copy/Copie Public**
Name of Director:	Karen Simpson
Order Type:	□ Amend or Impose Conditions on Licence Order, section 104 □ Renovation of Municipal Home Order, section 135 x Compliance Order, section 153 □ Work and Activity Order, section 154 □ Return of Funding Order, section 155 □ Mandatory Management Order, section 156 □ Revocation of Licence Order, section 157 □ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	Not applicable
Inspection #:	#2016_199626_0032 (A1)
Licensee:	CVH (No.6) GP Inc. as general partner of CVH (No.6) LP c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home:	Orchard Villa 1955 Valley Farm Road, Pickering
Name of Administrator:	Angela Rodrigues

Background:
On January 24, 2017 as part of inspection #2016_199626_0032 (A1), a Director Referral was made in accordance with s. 152, paragraph 4 of the LTCHA, 2007. The Director Referral was made after the inspector reissued a fourth consecutive compliance order under s O. Reg. 79/10 s. 131. This referral was specifically related to subsection s.131(2).

Order:	001

To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to: O.Reg. 79/10, s. 131. (2) Medications not administered as prescribed

Order:

The Licensee is ordered to provide the Director with a detailed written report on the status of actions taken to address the requirements of Order # 001 issued to the Licensee on January 24, 2017 as part of inspection #2016_199626_0032 (A1). In particular, the report is to identify the specifics of the nursing leadership provided by the management company, including their role, actions taken and attendance at the home. Further, the licensee is to provide the Director with a monthly update until September 30, 2017 demonstrating actions taken to ensure and sustain compliance.

In addition, the licensee is to provide the Director with a detailed plan identifying proposed actions to sustain compliance with s. 131 (2). That plan is to include the actions that will be taken, who will take these actions and when the actions will be completed.

The licensee is also ordered to provide ongoing and regular support by a nursing consultant to the registered nursing staff in the home and the Director of Nursing and Personal Care to ensure medication is administered as prescribed and corrective actions are taken in response to medication incidents. The nursing consultant will ensure:

- audits are being regularly conducted in the home;
- actions taken in response to concerns identified;
- education and re-education is completed as required; and
- that all of the above is documented to demonstrate compliance with this requirement.

Grounds:

- **November 15 to 27, 2015**: a Resident Quality Inspection was conducted at Orchard Villa. The inspection report and a compliance order CO #04 were served on the licensee on January 15, 2016. The compliance order (CO #004) was issued in relation to findings of non-compliance with O.Reg.79/10, s.131 (1) related to medication administration as medications were being administered to residents after they had been discontinued. Compliance due date was February 29, 2016. At the same time, medications were also not being kept secure or locked (issued O.Reg.79/10, s.129 (1)(a) as a WN). Appropriate actions were also not taken in response to medication incidents (issued O.Reg.79/10, s.134 (b) as a WN).

- **April 25 to May 4, 2016:** a Follow Up inspection was conducted. Non-compliance was found with O.Reg.79/10, s.131 (1) as medications continued to be administered after being discontinued. In addition, O.Reg. 79/10 s.131 (2) was issued as a medication was being administered with incorrect dosages. The inspection report and a compliance order CO #02 under s.131 (1) were served on the licensee on May 10, 2016 with a compliance due date of May 26, 2016..

- **July 5 to 18, 2016**: a Resident Quality Inspection was conducted at the LTC home. A follow-up inspection was conducted at the same time in relation to CO #02. Continued non-compliance were identified under O.Reg. 79/10 s. 131(1) & (2). The inspection report and a compliance order CO #02 and CO #03 were served on the licensee on September 8, 2016 with a compliance due date of October 31, 2016. Continued non-compliance was noted for O.Reg.79/10, s.131 (1) when the wrong medication was administered to a resident putting the resident at risk of harm. In addition, s. 131(2) was issued as an order due to medications being administered at incorrect times. The medication administration time for five residents was outside the parameter of the one hour window before or after the prescribed time of administration as per the licensee's policy.

- July 18, 2016: I met with the licensee and a LHIN representative to discuss the outstanding non-compliance in relation to O. Reg. 79/10 s. 131(1) & (2). This meeting was scheduled as a result of a Director's Referral issued by the inspector due to recurring non-compliance with this regulatory requirement identified during the Follow up inspection conducted between April 25 to May 4, 2016. At the time of the meeting it was identified that additional non-compliance was found during the Resident Quality Inspection conducted between July 5 to 18, 2016.

- By letter dated July 28, 2016,I requested a detailed plan from the licensee on the steps they were taking to address the non-compliance with O. Reg. 79/10 s. 131(1) & (2). I noted in the letter that the licensee had informed me that they were hiring an Assistant Director of Care as well as a Director of Quality Management. The plan was received as requested however on-going non-compliance has been identified in subsequent inspections.

    - **December 14 to 28, 2016:** a Follow Up inspection was conducted. Continued non-

compliance was noted for O.Reg.79/10, s.131 (2) and a compliance order (CO#01) was reissued and served on the licensee on January 25, 2017 with a compliance due date of February 28, 2017. The compliance date was amended February 8, 2017 to **March 31, 2017** at the licensee's request. The CO was reissued due to medications being administered at incorrect times and not as prescribed. The medication administration time for three residents was outside the parameter of the one hour window before or after the prescribed time of administration as per the licensee's policy. In addition, corrective actions were also not taken with medication incidents, as ordered and served on the licensee on September 8, 2016, in four of thirteen incidents that occurred after the compliance date of October 31, 2016.	
This order must be complied with by:	March 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
1075 Bay St., 11th Floor, Suite 1100
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.

Issued on this 10th day of March , 2017.	
Signature of Director:	
Name of Director:	Karen Simpson

Version date: 2017/02/15

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 5, 2017	2017_598570_0013	002465-17, 007052-17	Follow up

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): May 1-3, 2017

Follow up inspections:
Log #002465-17 related to compliance order #001 issued under inspection #2016_327570_0021 (A1) related to the home, furnishings and equipment not being maintained in a safe condition and in a good state of repair with a compliance due date of April 30, 2017; and

Log #007052-17 related to compliance order #002 issued under inspection #2017_360111_0001 (A1) related to dining services with a compliance due date of March 31, 2017.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, the acting Director of Care (DOC), Residents, Resident Care Area Manager (RCAM), Nutrition Manager, Food Services Workers (FSW), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Services Manager (ESM), Environmental Services Supervisor (ESS), and Housekeeping staff.

During the course of this inspection, the inspector toured the home, observed dining services, observed staff to residents interactions and provision of care, reviewed housekeeping and maintenance audit records, staff educational records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dining Observation

During the course of this inspection, Non-Compliances were not issued.
- **0 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2016_327570_0021	570
O.Reg 79/10 s. 73. (1)	CO #002	2017_360111_0001	570

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

Issued on this 5th day of May, 2017

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

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 8, 2017	2017_596571_0014	005615-17	Other

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

PATRICIA MATA (571)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): April 18, 19, 20, 21, May 1, 2 and 3, 2017.

This inspection was a follow up to a Director's Order issued on March 10, 2017 by Karen Simpson, Director, under the Act, as part of a Director Review for inspection #2016_199626_0032 (A1). At the time of this inspection, the Director's Order, related to O. Reg. 79/10, s. 131 (2) was found to be in compliance.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, the acting Director of Care, Nursing Consultants, Registered Nurses, Registered Practical Nurses, Resident Care Area Managers, Pharmacist, resident member of Resident Council and Residents.

In addition, the Inspector made observations of the units during medication passes and reviewed the following: clinical health records; administrative records, including schedules; audits; meeting minutes; education records, and reports.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were not issued.
- **0 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

Issued on this 8th day of May, 2017

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

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 8, 2017	2017_596571_0012	002485-17	Follow up

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

PATRICIA MATA (571)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 18, 19, 20, 21, May 1, 2, and 3, 2017.

The following was inspected: follow up inspection log # 002485-17 related to compliance order #001 issued under inspection # 2016_199626_0032 (A1) related to O. Reg 79/10, s. 131 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, the acting Director of Care, Registered Nurses, Registered Practical Nurses, Resident Care Area Managers, Pharmacist, resident member of the Resident Council and Residents.

In addition, the Inspector made observations of the units during medication passes and reviewed the following: clinical health records; administrative records, including schedules; audits; meeting minutes; education records, and reports.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were not issued.
- **0 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (2)	CO #001	2016_199626_0032	571

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.

Issued on this 8th day of May, 2017

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

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 9, 2017	2017_596571_0013	035088-16	Critical Incident System

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

PATRICIA MATA (571)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 3, 2017

Critical Incident Log #035088-16 related to an incident that causes injury to a resident for which the resident is transferred to hospital and which results in a significant change in health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Resident Care Area Manager, and SDM of resident.

In addition, the Inspector reviewed clinical health care records and observed the resident.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were not issued.
- **0 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

Issued on this 9th day of May, 2017

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

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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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
May 11, 2017;	2017_360111_0001 (A2)	035430-16	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

LYNDA BROWN (111) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Good afternoon Orchard Villa,
Here is the revised Inspection Report and Order for Compliance Order #003 for LTCHA, 2007, s.19(1). The compliance date was extended to June 30, 2017.
Thank you,
Lynda Brown, Nursing Inspector
Ministry of Health and Long Term Care

Issued on this 11 day of May 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

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
May 11, 2017;	2017_360111_0001 (A2)	035430-16	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

LYNDA BROWN (111) - (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): January 16-20, 23-27, 30 -31, February 1-3 & 8, 2017

The following inspections were completed concurrently with this inspection:

-Critical incident's related to allegations of resident abuse and/or neglect (02731-16, 023595-16, 026513-16, 034777-16, 033626-16, 034747-16, 000992-17, 002431-17, 002520-17)

-Critical incident's related to fall resulting in an injury and transfer to hospital (030254-16)

-Complaints related to staff shortages, of supplies, and food quality (022231-16, 025341-16, 033948-16)

-Complaints related to allegations of staff to resident abuse and/or neglect; poor pain management; and medication administration (034747-16 & 034927-16; 030157-16; 030904-16)

-Critical incident related to responsive behaviour (024245-16)

During the course of the inspection, the inspector(s) spoke with the Administrator, acting DOC, Registered Nurses (RN), Registered Practical Nurses (RPN), Environmental Services Manager (ESM),Nutritional Care Manager (NCM), Dietitian, maintenance, Physiotherapist (PT), Dietary Aides (DA), Housekeepers (HSK), Personal Support Workers (PSW), Social Worker (SW), Laundry Aides,

Cooks and RAI Coordinator, Resident Council President, and Residents.

During the course of the inspection, the inspector(s) also toured the home, observed dining services, observed a medication administration pass, observed supplies,and measured lighting levels throughout the home, reviewed resident health records, reviewed Resident Council Meeting minutes, reviewed the home's complaints and investigations, and reviewed the following policies: Zero Tolerance of Abuse and Neglect, Weights, Responsive Behaviours, Complaints and Customer Service.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

23 WN(s)
7 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rules related to doors were complied with:
Doors that residents had access to and led to stairways and unsecured outdoor areas of the home were not equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and were not connected to the resident-staff communication and response system.

A) Eight doors leading to stairwells to which residents had access were checked. These doors were located in the main foyer (near the elevator), two in the Birch home area, one in the Linden home area, two in the Cedar home area and three in the Aspen home areas and did not have an audible alarm located at the door. When each door was tested, it was confirmed to be connected to the resident-staff communication and response system (at various enunciator panels) and an audible sound within the corridors was heard. However, each door did not have a separate audible alarm at the door that would sound until a staff member cancelled the alarm at the door.

B) The front main entrance door to the long term care home, which led to an unsecured outdoor area was not equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and was not connected to the resident-staff communication and response system. When the door was tested, the Linden area nursing station was identified by staff as the closest station to the door. The audio visual enunciator located at the nurse's station included a visual light labelled "front door", but it did not light up when the door was left open for more than one minute. The exit door leading from the Aspen home area to an unsecured outdoor area did not have an audible alarm at the door and it could not be confirmed if the door was connected to the Aspen home area audio visual enunciator.

C) Two stairwell doors accessible to residents in the basement (near the recreation room and chapel) were not equipped with an audible door alarm or connected to the audio visual enunciator at the Maple nurse's station. Management staff could not confirm if the doors were connected to any of the other enunciator panels within the home. Maintenance staff could not provide any drawings or a reference confirming which stairwell door and which door leading to the outside was connected to which enunciator panel and were not aware that the doors were not connected to the resident-staff communication and response system (via enunciator panels).

D) Two sets of glass doors leading to the retirement home area located in the basement (near the auditorium and a stairwell) and one set of doors located on the main floor leading to the retirement home area were not connected to any audio visual enunciator at any of the nurse's stations and were therefore not connected to the resident-staff communication and response system. The doors were not equipped with an audible alarm. Doors that separate a retirement home from a

long term care home area considered the equivalent of doors leading to an unsecured outdoor area. [s. 9. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a process to ensure that food service workers and other staff assisting residents were aware of the resident's diets, special needs and preferences. [s. 73. (1) 5.]

Observation of the lunch service in the main dining room (Linden servery) on a specified date by Inspector #111 indicated the dietary aide (DA #109) did not refer to the resident diet list while providing resident meals. PSW # 114 requested the meal choice and texture but did not identify the resident names when requesting food plates from the DA. PSW # 113 was requesting meal choice by resident names only and the DA did not refer to the resident diet list to ensure they received the correct diet and texture. The DA began asking the nursing staff to refer to the resident diet list after the inspector asked the DA why the resident diet list was not referred to.

Interview with the Nutritional Care Manager (NCM), by Inspector #111 indicated it is the DA responsibility to refer to the diet list prior to serving meal choices for each resident, not the nursing staff.

2. The licensee failed to ensure that residents were provided with any eating aids, assistive devices, personal assistance and encouragement that was required to safely eat and drink as comfortably and independently as possible. [s. 73. (1) 9.]

An observation of the lunch meal service on a specified date, in the large main dining room was completed by Inspector #623. Resident #018, #060 and #062 were seated at the same table and the food was placed in front of these three residents. All three residents made no attempt to eat the meal. PSW#126 sat with resident #062 fifteen minutes later and began assisting with feeding. There was no verbal communication, no verbal cues or encouragement to eat their meals by PSW #126. Approximately half an hour later, all three residents had been removed from the table. Resident # 018 & #060's meal was untouched. Resident #062 had consumed 50% of meal (with staff assistance) and no dessert was offered to any of the three residents. Resident #002 was observed sitting at a different table and a plate of food was placed in front of the resident. The resident made no attempt to eat and the food was sitting for approximately 20 minutes in front of resident #002 when PSW #143 was observed removing the plate from the resident without asking the resident if the resident was finished eating or offering assistance. Resident #002 did not receive any lunch.

Interview with PSW #143 by Inspector #623 confirmed the plate was removed from resident #002, the meal was untouched and the PSW did not offer assistance to resident #002 . Interview with PSW #126 by Inspector #623, confirmed that residents #018, #060 and #062 require monitoring throughout the meal with verbal cuing and assistance if they do not eat. PSW#126 was unable to confirm the intake

for these residents at lunch.

3. An observation of the lunch meal service on the following day in the large main dining room was completed by Inspector #623 and residents #018, #060 and #062 had plates of food placed in front of these residents. The plates were removed approximately half hour later and the food was left untouched. No dessert was offered to any of these residents. Residents #018, #060 and #062 were not offered encouragement or assistance at any time throughout the meal. Resident's #060 and #061 did not receive any fluids. None of the three residents received their lunch meal. Resident #002 was observed to receive a plate of food at a specified time when PSW#126 sat down and fed resident#002 three bites of food and then left the table. The resident made no attempts to feed self. PSW#126 stated out loud "someone needs to feed, we have no one" and then continued to serve other tables. Approximately 20 minutes later, the plate of food was removed from resident #002. Resident #002 did not eat the remainder of the meal and dessert was also not offered to resident #002.

Interview with PSW#156 by Inspector #623, indicated that resident #002 requires assistance to eat "sometimes, but not today" and indicated resident #002 had consumed all of lunch meal as well as dessert today.

Review of the clinical records for residents #002, #018, #060, and #062 indicated that all four residents require staff to verbally cue and encourage to eat throughout the meal and staff are to provide assistance to eat if necessary. All four residents had experienced recent weight loss and were identified as high nutritional risk.

The licensee has failed to ensure that residents #002, #018, #060 and #062 were provided with the personal assistance and encouragement required to eat and drink as independently as possible.

4. An observation of the lunch meal service on a specified date in the large main dining room was completed by Inspector #111 and identified the following:
-resident #002 had a pureed meal placed in front of the resident. The resident made no attempt to eat the meal and no assistance or prompting was provided. Approximately 15 minutes later, PSW #115 then provided the resident two spoonfuls of food and then left the resident. No other assistance or encouragement was provided for the remainder of the meal and the resident did not receive the remainder of the meal.
-Resident #003 had completed the lunch meal and had asked PSW # 115 for

desert. The PSW indicated the resident would have to wait. The resident continued to ask three other staff for desert before it was provided. The resident expressed frustration with staff ignoring request for desert.
-Resident #055 had a pureed meal placed in front of the resident. The resident made no attempt to eat the meal and no assistance or encouragement was provided to the resident for a period of approximately 15 minutes when a staff member fed the resident the lunch meal and desert.
-Interview of PSW # 126 & #156 indicated resident #002, #003 and #055 required encouragement and/or total assistance with feeding of meals.

Review of the clinical records for residents #002, #003 and #055 indicated that resident #002 required staff to either verbally cue and encourage to eat throughout the meal and/or staff are to provide assistance to eat if necessary. Resident #003 and #055 required total assistance with feeding at meals. All four residents had experienced recent weight loss and were identified as high nutritional risk.

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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from staff to resident verbal or physical abuse and/or neglect by staff and other residents, and failed to ensure vulnerable, cognitively impaired, residents were protected from alleged, suspected or witnessed sexual abuse by another resident, pursuant to s.19 of the LTCHA.

Under O.Reg. 79/10, s.2(1) For the purposes of the definition of "abuse" in subsection 2(1) of the Act, “sexual abuse” means,(a) subject to subsection (3), (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Under O.Reg. 79/10, s.2(1), For the purposes of the definition of "abuse" in subsection 2(1) of the Act,
-"emotional abuse" means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour, or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a residents.
-"physical abuse" means, subject to subsection (2)(a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Under O.Reg. 79/10, s. 5, For the purposes of the definition of "abuse" in subsection 2(1) of the Act, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

1. Related to log #001738-17:

Critical Incident Report (CIR) was submitted to the Director on a specified date related to an alleged staff to resident verbal and physical abuse that was reported to Inspector #626 in stage one of the RQI. Inspector #626 reported the alleged incidents to the Administrator on the same day. Resident #010 reported the previous evening, two staff were rough when providing care and resulted in pain. The resident also indicated that PSW #139 and PSW #149 also made inappropriate comments towards the resident regarding personal care. The resident indicated the incidents were reported to RPN #120 the following morning (the same day the Inspector was notified). The RPN did not report the allegation to

the RN, DOC or Administrator until the following day during the investigation.

Interview with RPN #120 by Inspector #626 confirmed that the resident did report the alleged inappropriate comments made by the PSW #139 and #140 but was not informed of any incidents of physical abuse or rough handling. The RPN was uncertain of the date the RPN was informed. The RPN indicated was not informed of any incidents of physical abuse or rough handling. RPN #120 indicated that the resident had requested the RPN not to report the allegation but should have reported it immediately.

In an interview with the Administrator by Inspector #626 indicated that RPN #120 did not immediately report the allegations of staff to resident verbal abuse until the home's investigation the day after the allegation was received. The Administrator indicated that it is the expectation that staff report incidents of abuse immediately to their RN supervisor.

The licensee failed to ensure the written policy that promotes zero tolerance of abuse and neglect of residents was complied with as RPN #120 failed to immediately report an incident of staff to resident rough handling and emotional abuse as issued under WN #14 under s.20(1)(a)(626).

2. Related to log #020568-16:

A critical incident report (CIR) was submitted on a specified date for an alleged staff to resident neglect. The CIR indicated at a specified time, resident #015 was observed yelling and making threatening remarks towards resident #053. The incident was witnessed by PSW #151 and PSW #152, who did not intervene. RPN #132 then witnessed the incident and intervened. RPN #132 forwarded a complaint regarding the incident the same day indicating the staff failed to intervene. The CIR was not amended to provide the outcome of the licensee's investigation into the allegation.

An off-site enquiry was made to the Administrator on a specified date requesting the outcome of the licensee's investigation but the information was not provided. An inspection was then initiated a week later and the Administrator was asked for the investigation and outcome of the investigation. One staff interview was provided to the inspector at that time but no outcome of the investigation. Review of the health record of resident #053 indicated there was no documented evidence of the incident or to indicate the resident was assessed as per the home's Zero

Tolerance of Abuse policy. Further interview with Administrator confirmed she should be interviewing all staff who may have been involved in the incident, documenting the outcome of the investigation and the CIR should have been updated with the outcome.

Interview with Social Worker (SW) indicated she is responsible for maintaining the home's complaint log and enters all verbal and written complaints that are received once the investigations are completed. The SW was not aware of any verbal complaint received by the home on the specified date regarding allegations of staff to resident neglect towards resident #053. The SW indicated the acting DOC or Administrator are responsible for providing all verbal or written complaints to the SW.

-Review of the home's investigation and interview of staff indicated the home's Zero Tolerance of Abuse policy was not followed as: there was no documented evidence of the incident or to indicate resident #053 was assessed or offered support related to verbal abuse received by resident #015. The two PSW staff also failed to intervene as issued under WN #14 under LTCHA, 2007, s.20(1)(a).
- The licensee failed to ensure that a documented record was kept in the home that included: the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response, and; any response made by the complainant the verbal complaint made by the RPN regarding neglect was not documented in homes complaint log as issued under WN #22 under O.reg. 79/10, s.101(2)
-The CIR was not updated within 21 days of the incident, with the outcome of the investigation as the CIR was not updated as of the time of the inspection, six months later, as issued under WN #23 under O.Reg. 79/10, s.104(3).

3. Related to log # 002431-17:

Critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect that occurred over a two day period at specified times. The CIR indicated resident #061 (who is cognitively well) had reported staff to resident neglect towards resident #057 by PSW #129. Resident #061 reported additional staff were also aware of the incident. The CIR did not indicate which staff were involved in the allegation.

Interview with Administrator and acting DOC by Inspector #111, indicated PSW #129 was involved in the alleged neglect and resident #061 (who reported the allegation), were both interviewed two days later. The Administrator indicated the home determined the PSW #129 had provided care related to toileting to resident #057 on both dates. The Administrator indicated that PSW #129 could not provide a specified task due to lack of supplies available. Interview of the Administrator the following day indicated she forgot that she had also interviewed three other PSW's on the same day the allegation was made but did not document the interviews. The Administrator concluded the investigation and indicated the allegations were unfounded.

Review of the current written care plan for resident #057 indicated the resident is at risk for skin breakdown related to incontinence and interventions included: resident will not call for assistance with toileting, staff are to check and change the resident every 2-3 hours and as needed.

Review of the licensee's investigation, interview of staff, and review of the resident #057 health record indicated a complaint was received by resident #061 on a specified date regarding an allegation of staff to resident neglect that occurred towards resident #057 by PSW #129. The home's investigation indicated that PSW #123, #139, #145, #165 were involved or present in the allegation and their names were not provided in the CIR. The outcome of the investigation was unfounded despite the licensee's investigation indicating PSW #129 did not provide care to resident #057 as indicated in the plan related to toileting. PSW #123 reported assisting PSW #129 with toileting of resident #057 once per shift on the specified dates and indicated resident #057 required more frequently toileting. Interview with PSW #139 by Inspector #111 indicated resident #057 required toileting 3-4 times per shift. Resident #057 was not toileted as indicated in the plan.

-There was no documented evidence of the incident or to indicate resident #057 was assessed, as per the home's Zero Tolerance of Abuse and Neglect policy, as issued under WN #14 under LTCHA, 2007, s.20(1)(a).
-There was no documented evidence the investigation was completed immediately and no actions were taken related to the resident not being toileted as per the resident's plan of care or the lack of supplies available to complete a specified task as issued under WN #15 under LTCHA, 2007, s.23 (1)(a).
-The care set out in the plan of care was not provided to the resident as specified in the plan related to toileting as issued under WN #12 under LTCHA, 2007, s.6(7).

-The CIR was not amended to indicate which staff were involved with the allegation despite staff awareness two days after the allegation was made, as issued under WN #23 under O.reg.79/10, s.104(1)2.

4. Related to log # 027318-16:

The Ministry of Health after hours was called on a specified date to report an incident of injury of unknown cause to resident #045. A CIR was not submitted at that time. A CIR was submitted four months later as a result of an off-site enquiry. The CIR indicated at a specified time, RPN #117 noted an injury to a specified area to resident #045 and suspected rough handling by a staff or resident. The CIR indicated the outcome was pending the investigation. The CIR indicated the SDM was not notified of the incident.

Interview with the Administrator by Inspector #111 requesting the outcome of the investigation indicated the investigation was not yet completed (five months later). The Administrator confirmed the SDM was not notified of the incident.

Review of resident #045 progress notes indicated on a specified date and time, an RPN noted an injury to a specified area and suspected possible rough handling by a staff or resident due to location of injury. The RPN interviewed the PSW who was assigned to resident #045 and confirmed the injury was noted at start of shift but did not report to the RPN. The home did not complete the investigation to determine if the investigation was founded or unfounded. The home also failed to submit the CIR within 10 days of the incident. The licensee's Zero Tolerance of Abuse and Neglect policy was not complied with as an injury of unknown cause was not immediately reported by the PSW and there was no documented evidence to indicate that appropriate actions were taken.

-Review of the home's investigation and interview of staff indicated the home's Zero Tolerance of Abuse and Neglect policy was not followed related to failure to immediately report the injury suspected physical abuse as issued under WN #14 under LTCHA, 2007, s.20(1)(a).
-The licensee failed to ensure the resident's SDM and any other person specified by the resident, were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being as issued under WN #21 under O.Reg. 79/10, s.97(1)(a).

-The licensee failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director as issued under WN #23 under O.Reg. 79/10, s.104(2).

5. Related to log #002520-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse that occurred on the same day at a specified time. The CIR indicated program staff (PS #171) had reported resident #046 had reported being rough handled earlier in the day during care and had been occurring over the last two weeks to RN Manager #118 (the same day).

Review of the care plan for resident #046 indicated the resident had specified sleeping preferences.
Review of the licensee's investigation indicated on the specified date and time, resident #046 reported the PSW "is rough" and was upset and weepy while reporting the incident to PS #171. The SDM of resident #046 was present when the allegation was reported to PS #171 and confirmed incidents had been occurring over a two week period. RN Manager #118 did not report the allegation until the following day, when the police were notified. RN Manager #118 indicated the alleged PSW involved in the incident was PSW #172 and was interviewed two days later.

Interview with the Administrator by Inspector #111, confirmed that no other staff were interviewed regarding the allegation, the investigation was completed and determined to be inconclusive. The Administrator indicated as a result of the discussion with the Inspector, that other staff would be interviewed before the home determined the outcome.

-The investigation was not completed immediately as the investigation did not start until two days after the allegation was made of staff to resident rough handling and no other actions were taken to prevent a recurrence despite the resident not receiving care as per the resident's written plan of care, as issued under WN #15 under LTCHA, 2007, s.23(1)(a).
-The care set out in the plan of care was not provided to the resident as specified in the plan related to sleep preferences as issued under WN #12 under LTCHA, 2007, s.6(7).

6. Related to log # 033626-16 & # 034927-16:

A critical incident report (CIR) was received on a specified date for an allegation of staff to resident neglect. The CIR indicated the SDM of resident #049 brought forth complaints to RN Manager #118 regarding improper care and neglect to resident #049 by PSW #144. The CIR indicated the SDM also submitted a written complaint eight days later regarding the incidents that occurred and the resident "was upset" and requested not to have the same PSW providing care for the resident.

Review of the written complaint from the SDM of resident #049 indicated on a specified date and time, the resident reported PSW #144 had provided improper care and neglected the resident throughout the shift. The SDM indicated the allegations were reported to the acting DOC the same day they occurred as the resident was in discomfort. The SDM indicated PSW #173 and RPN #137 were also aware and or present when the improper care and neglect occurred.

Interview with acting DOC and RN Manager #118 by Inspector #111, confirmed the home was aware of a verbal complaint alleging staff to resident neglect on the day the incidents occurred (followed by a written complaint seven days later) and the investigation was not initiated until four days later. The acting DOC indicated the SDM was notified the outcome of the investigation was inconclusive.

Review of resident #046 progress notes had no documented evidence of the allegation or indication of an assessment of resident #046 related to the discomfort. The licensee’s investigation indicated the resident (who was capable) was never interviewed regarding the incident and no indication any emotional support was provided.

Interview with Social Worker (SW) indicated she is responsible for maintaining the home's complaint log and enters all verbal written complaints that are received once the investigations are completed. The SW was not aware of any verbal or written complaint received by the home on specified dates regarding allegations of neglect towards resident #049.The SW indicated the acting DOC or Administrator are responsible for providing all verbal complaints (via client feedback forms) or written complaints to the SW.

Review of the home's complaint log for the two specified months did not have any indication of a verbal or written complaint received by the SDM of resident #049 related to neglect.

Review of the licensee's investigation and interview of staff indicated the home was aware of allegations of improper care and neglect towards resident #049 "who was upset" and in discomfort, on the day the incidents occurred, and the Director and police were not notified until the following day. The licensee's investigation and interview of staff by Inspector #111 indicated RPN #137, PSW # 173, PSW #174 and PSW #175 were present and or aware of the allegations and were not identified on the CIR. The home informed the family that the outcome of the investigation was "inconclusive" and PSW #144 was allowed to continue to provide care to resident #049.

-Review of the licensee's investigation and interview of staff indicated the licensee's policy was not followed related to the investigation process and there was no documented evidence the resident was assessed related to allegations of staff to resident neglect as issued under WN #14 under LTCHA, 2007, s.20(1)(a).
-There was no indication the investigation was completed immediately and there was no indication that appropriate actions were taken as a result of the licensee's investigation, when the allegations were confirmed, as issued under WN #15 under LTCHA, 2007, s.23(1)(a).
-The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: 1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm as issued under WN #16 under LTCHA, 2007, s.24 (1).
-The licensee failed to ensure that the report to the Director included the following description of all of the individuals involved in the incident: (ii) names of any staff members or other persons who were present at or discovered the incident as issued under WN #23 under O.Reg. 79/10, s.104 (1)2.
-The licensee failed to ensure that a documented record was kept in the home of a verbal and written complaints received in November and December 2016 that included: the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response, and; any response made by the complainant as issued under WN #22 under O.reg. 79/10, s.101(2)

7. Related to log # 023595-16:

A critical incident report (CIR) was submitted to the Director on a specified date for an allegation of resident to resident sexual abuse. The CIR indicated on a specified date and time, resident #043 and resident #044 were found demonstrating sexually inappropriate behaviour in resident #044 room and were not separated by staff for a specified period of time. Both residents were then supervised by staff for a specified period of time when resident #043 was redirected out of resident #044 room. The CIR indicated both residents are cognitively impaired and "neither resident is able to provide consent for sexual behaviour". The CIR indicated “Internal Investigation initiated". The CIR was not amended to indicate the outcome of the home's investigation. The CIR indicated 1:1 staffing was put in place and referral to BSO as a result.

Observation of resident #043 on a specified date by Inspector #111 indicated the resident was cognitively impaired and was independently mobile with use of a mobility aide. Resident #044 was no longer in the home.

Review of the progress notes for resident #043 and #044 related to sexually inappropriate responsive behaviours and/or sexual abuse indicated:the behaviours occurred over a three month period but in both residents’ progress notes, the co-residents were not identified. There were seven documented incidents where resident #043 & #044 were observed demonstrating sexually inappropriate responsive behaviours. There were 2 incidents where suspected resident to resident sexual abuse and two incidents of suspected resident to resident sexual abuse that were not documented to indicate when they occurred and with whom.

The triggers and strategies for both resident #043 & #044 did not indicate which female/male resident(s) they were having inappropriate sexual behaviours towards; Resident #043 had demonstrated inappropriate sexual responsive behaviours towards more than one co-resident and this trigger was not identified; The plan of care did not clearly indicate what the “sexually inappropriate” behaviour included despite the progress notes for both residents clearly indicating what these behaviours and triggers included. The incident of resident #043 inappropriately touching another unidentified co-resident (as reported by an RN during an interview) was also not identified to indicate when it occurred and towards whom. The strategies to manage the sexually inappropriate responsive behaviours was also not clear as there was no indication how staff would monitor each of the two residents or what “increased observation” included. The observation period was unclear and sometimes resident #043 was placed on 1:1 and other times on every 15 minute observations. The sexually inappropriate responsive behaviours was

accepted by some staff as a 'relationship' and therefore did not intervene. The relocation of resident #044 to another unit was used as a strategy but was not considered until after the seventh incident and despite permission provided by the SDM after the fifth incident. There was no indication of a referral to psychogeriatric services despite the ongoing behaviours of sexually inappropriate behaviours and BSO discontinued resident #043 from the program despite continuing to display sexually inappropriate responsive behaviours.

Interview with Administrator by Inspector #111 regarding the incident indicated an investigation was completed but she was unable to locate the investigation. The Administrator indicated she was unaware the CIR was never amended to indicate the outcome of the home' investigation.

- There was no indication the investigation was completed immediately and appropriate actions were taken as the investigation had not yet been completed or concluded five months later, as issued under WN #15 under LTCHA, 2007, s.23(1)(a).
-The licensee failed to ensure that for resident #043 & #044 demonstrating sexually inappropriate responsive behaviours, the behavioural triggers for the resident were identified, where possible, strategies were developed and implemented to respond to these behaviours, where possible, and actions were taken to respond to the needs of the resident, including assessment, reassessments and interventions, and that the resident's responses to the interventions are documented as issued under WN #17 under O.Reg. 79/10, s.53(4)(a)(b).

8.In addition, the licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected and did not contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate, as issued under WN #20 under LTCHA, s.96(a)(b).

A Compliance Order was warranted as the scope and severity was demonstrated by the following:
1. A Compliance Order (CO #001), was issued during a Critical Incident Inspection (#2015_360111_0014), on June 3, 2015, under LTCHA, 2007, s.19(1), which included a written notification (WN) specific to LTCHA, 2007, s. 6(7), 20(1), 23(1)(a), 24 (1), 97(1) & 98 with a compliance date of August 15, 2015. A second CO (#

001), was issued during the Resident Quality Inspection(RQI) (#2015_365194_0028), on November 16, 2015, under LTCHA, 2007, s19 (1) which included a WN specific to LTCHA, 2007, s.20(1), 23(2) and s.24(1) with a compliance date of April 30, 2016. The order was complied with on August 5, 2016. In addition, LTCHA, 2007, S.23 (2) was issued during a Complaint Inspection (#2016_327570_0010), on April 25, 2016 which included a voluntary plan of correction (VPC) and O.Reg.79/10, s.104(2) with a WN at that time. A WN was issued during the RQI (#2016_327570_0014) for LTCHA, 2007, s.23(2). A WN was issued during RQI (#2016_327570_0014) for O.Reg.79/10, s.104(1)2. A WN was issued during a Complaint Inspection (#2016_327570_0022) specific to LTCHA, 2007, s. 6(7).
2. There was actual harm to residents related to physical, emotional, and sexual abuse towards multiple residents (both cognitively well and cognitively impaired resident). There was also a pattern of inaction related to allegations and complaints of staff to resident neglect as demonstrated by the above logs. [s. 19. (1)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 003

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

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee did not ensure that elevators within the long term care home were equipped to restrict resident access to areas that were not to be accessed by residents.

The home was equipped with two elevators which led to areas that had unsafe conditions or had unlocked exit doors to unsecured outdoor areas. Non-compliance was previously identified on inspection report # 2016-327570-0014 (dated September 8, 2016). A written notification was issued with a voluntary plan of compliance to address the issues. On January 16-20, 25 and 26, 2017, two separate elevators within the long term care home were operational and accessible to residents and restrictions were limited or not evident.

Elevator #1 located within the newer section of the building permitted limited access to inspector #120 to the basement, located below the Aspen and Cedar home areas. Access to the elevator on both first and second floors was granted by entering a code on a key pad to release the magnetic locks on doors that were located on either side of the elevator foyer. Although resident access to the elevator entrance via Aspen or Cedar home areas was restricted, the elevator was available for resident use to access the laundry room. According to one resident, they knew the code to leave their home area and often used the elevator to go to the laundry room to get their clothing labelled. If residents were aware of codes to exit their home areas, they therefore had access to the basement via the elevator. The basement included four exits, three to unsecured outdoor areas and one to the retirement building. On January 25, 2017, the exits were all unlocked with the exception of one in the garbage room. However this door was found unlocked on January 16-20, 2017 by inspector #623 and #111. The elevator, when used, also permitted inspector #120 to open the back door into the server's of both Aspen and Cedar by pressing one button on the elevator panel. Both servers were equipped with steam tables and hot water machines.

Elevator #2 located within the older section of the building permitted unrestricted access to various inspectors between the main floor (resident rooms), second floor (unoccupied offices, washroom and boardroom) and the lowest level of the building. The elevator was observed to be used by visitors, staff and residents without any limitations. The lowest level consisted of shared spaces, used by staff, retirement home residents and long-term care residents. However, with the exception of the laundry room, the areas were not continuously monitored by direct care staff. They included a chapel, hair salon, atrium, library, recreation room, staff

locker room, staff lunch room, auditorium, laundry room, outdoor courtyard and an entrance to the retirement building. The atrium included an open stairwell and a koi fish pond. The open stairwell consisted of 18 stairs leading up to a dining room with a locked gate at the top. It was not restricted at the bottom to prevent residents from trying to use the stairs and possibly falling while on the stairs. A koi fish pond was observed along one wall of the atrium and the edge was lined with medium sized rocks that could be picked-up. The koi pond was not designed to prevent safety hazards such as tripping into the pond, which was approximately three feet deep and a concern for visitors and residents.

Management of the home reported that elevator #1 was to be equipped with a key pad to restrict residents from accessing the lowest level and servery's on January 25, 2017. However, the elevator contractor could not complete the work due to inaccurate electrical drawings. Completion of the work was scheduled for February 10, 2017. On January 26, 2017, no specific plans were provided by management regarding resident access to the lowest level via elevator #2 as it was used regularly by retirement home residents as a short cut into the retirement home via the lowest level. A memo dated January 20, 2017 was posted in various home areas with a message that the elevator would be available only between the hours of 6 a.m. and 9 p.m. and use after that time would require the assistance of a nurse. The memo was not posted until inspectors raised concerns to management staff about unrestricted access to the elevator on January 18 and 19, 2017. On February 2, 2017, management staff decided to install key locks on all doors leading to the atrium to prevent unsupervised access to the space by long term care residents. [s. 10. (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 both elevators in the home are equipped with devices to restrict resident access to areas that are not to be accessed by residents, to be implemented voluntarily.

WN #5: 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 the home, its furnishings and equipment were kept clean and sanitary.

Observation of the lunch meal service on a specified date by Inspector # 111, indicated the Linden servery in the main dining room had a glass partition that was heavily soiled with food prior to the meal being served. The wall to the right side of the servery glass also had a large food spill from above the glass partition, down to the floor. Three days later, both areas remained soiled until the Inspector reported the areas to the Administrator and Dietary Consultant.

Interview with the NCM by Inspector #111 indicated it was the responsibility of dietary staff after each meal to clean the glass partition at the Linden servery in the main dining room. The FSM stated "it would be common sense that after a spill of food, either the nursing staff or dietary staff would clean up the spill". The NCM indicated there was no specific job task related to each of the these areas as it is just a part of the DA responsibilities. [s. 15. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's furnishings and equipment and kept clean and sanitary, specifically in the main dining room, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

The activation station, which is a component of the resident-staff communication and response system, could not be seen or accessed by inspector #120 in the restorative care room. Restorative care staff identified the activation station behind a large cabinet where it could not be easily seen, accessed or used by residents, staff or visitors. [s. 17. (1) (a)]

2. The licensee did not ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

The Pine activity room (with sink and fridge) and the Pine sitting room (with television set), which were both fully accessible to residents, were not equipped with an activation station, which when used, would alert staff to the location of the alarm. [s. 17. (1) (e)]

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 is equipped with a resident to staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times in the restorative care room and Pine unit activity and sitting lounges, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee failed to ensure that the lighting requirements set out in the lighting table were maintained.

An inspection was previously conducted on December 6 and 7, 2016 by Inspector #111 to determine compliance with this section. Non-compliance was identified and a written notification was issued with a voluntary plan of compliance to address the issue.

During this inspection, no changes to the lighting levels from December 7, 2016 were identified with the exception of one resident room on the Birch unit (B9) and one section of corridor (in the Linden unit) which were equipped with new LED lights and being used as test locations. The areas were measured by Inspector #120 on January 26, 2017 using a hand held digital light meter (Amprobe LM-120, accurate to +/- 5%) and determined the lighting levels exceeded the minimum lighting requirements.

The non-compliance identified on December 6 and 7, 2016 are as follows and were confirmed on January 26, 2017:
-The long term care home was built prior to 2009 and therefore the section of the lighting table that was applied is titled "all other homes". A hand held digital light meter was used (Amprobe LM-120, accurate to +/- 5%) and held a standard 30 inches above and parallel to the floor. Not all areas of the home were measured due to the inability to block out all sources of natural light. These included the main foyer, activity rooms and lounge spaces. The areas in the basement accessible to residents such as the chapel, library and recreation room were not measured but appeared to be poorly lit. Only a small sample of resident bedrooms and en suite washrooms were measured as all these types of rooms contained the same number, size and style of lighting fixtures and natural light could be controlled. Resident en suite washrooms met the minimum lighting requirements.

In bedrooms tested, all available lights were turned on and allowed to warm up. All doors and bedroom window coverings were closed in an effort to reduce the influence of natural light. When light levels were measured in semi-private or ward resident bedrooms, the privacy curtains between each bed was drawn, to further reduce the influence of natural light in the area of the entrance and around each

bed.

The following areas did not meet the minimum lighting requirements:

Corridors:

The lighting levels in the corridors on Linden, Birch, Maple and Pine were very low and did not meet the minimum requirement of 215.28 lux consistent and continuous lighting along the corridor. The lighting fixture styles varied and were different in Maple from the other three corridors. The fixtures in Maple were spaced 22 feet apart and ranged from 400 lux (directly under a light fixture) to 20 lux (between light fixtures). The fixtures in the other corridors were approximately eight feet apart and measured between 30 and 75 lux between fixtures.

The lighting level in the corridor in front of the main dining room (at entrance of the home) was 150-170 lux. This area was used by nursing staff to place medication carts in order to dispense medications for residents in the dining room.

Main Dining Room:

The main dining room was equipped with numerous light fixtures spaced out evenly over the ceiling area. The fixtures included a mix of round flush ceiling mounted dome lights with two bulbs and glass lens and suspended pendant lights with inverted large opaque glass lens. The levels achieved were approximately 150 lux under the lights and 100 lux between the lights, in areas between tables or path of travel. The levels did not meet the minimum requirement of 215. 28 lux.

Resident bedrooms:

The home consisted of three different bedroom types, a private, semi private and ward bedroom. The majority of the bedrooms were equipped with the same number, type and style of fixture. Lux levels were taken in areas of activity (in front of closet, around each bed and path of travel from front door to bed). Upon entry to each bedroom type, a small ceiling mounted dome shaped light with a single bulb was noted with an opaque lens. The centre of each room was equipped with a suspended pendant fixture with two compact fluorescent bulbs and inverted glass lens. Each bed had an over bed light, which was determined to be adequate, as long as both fluorescent tubes in the fixture were working.

The lighting levels in resident rooms on both the Birch and Linden home areas (one private, one ward and three semi private rooms) were measured. The ranges included 50-100 lux at the entrance, 65-140 lux around each bed, 30-110 lux in front of closets/wardrobes. The minimum required level of 215.28 lux was not provided. [s. 18.]

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 the lighting requirements set out in the lighting table for homes built before 2009 were maintained, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all foods and fluids are prepared, stored and served using methods which preserve taste, nutritive value, appearance and food quality.

Related to log # 025341-16:

A complaint was received on a specified date indicating the food is overcooked and tasteless. The food portions are small for the residents who can't speak for themselves.

Interview with resident #052 by Inspector #623, indicated that the food quality is poor, especially the meat, and the chicken and sausage were always overcooked. Resident #052 indicated attends Food Committee meetings and brings these concerns forward to NCM #158. Resident #052 stated that she/he often chooses to not eat the food due to being overcooked.

Observations by inspector #623 in the large dining room on specified date and time had sausages being served as the alternative meal choice for residents. The sausages appeared overcooked. Staff were observed having difficulty attempting to cut the overcooked sausage for resident #056. Resident #056 was observed attempting to eat a piece of the overcooked sausage and was unable to chew it, so proceeded to spit out the food. Inspector #623 interviewed resident #056 and stated "the meat it too tough. It is always tough." Resident indicated was not able to eat the meat as a result. Observations in the large dining room also revealed seven resident plates that were cleared where the residents left the overcooked sausage on the plate uneaten.

During the same lunch service the Extendicare Dietary Consultant (RD #159) confirmed that the sausages served were tough and overcooked and would follow up with the Dietary Manager and NCM #158.

Interview with Cook#161 and Cook#160 by Inspector #623, indicated that the oven does not cook the food evenly and the right side of the food on the trays will burn before the left side is cooked. Cook #160 confirmed that today half of the tray of sausages were overcooked. The cook indicated that the overcooked sausages were supposed to be served last, that this happens a lot with the meat, there is never any extra meat to cook in order to replace the overcooked meat, so the meat is served to the residents anyway or they would not have enough. Cook #160 indicated the issue with the oven has been ongoing for at least seven months. Cook #160 confirmed never reporting the issue to the Nutritional Care Manager (NCM) #158.

Interview with NCM #158 indicated that he was not aware that there was a problem with the oven not cooking the food evenly. He has not been notified by the cooks that there was a problem. NCM was unable to confirm when the ovens were last

serviced. NCM agreed the sausages that was served the same day appeared overcooked and tough.

Interview with the Administrator by Inspector #623, she agreed the sausages appeared overcooked and tough. The Administrator agreed that the food did not look appetizing or palatable. She indicated that she was not aware there was a problem with the oven not cooking evenly. The Administrator indicated that there are food audits completed by the NCM monthly to evaluate the food quality. The Administrator indicated that there is record of one service to the ovens in 2016 as evidenced by the invoice provided. This service completed was to the top convection oven for replacement of the electronic temperature control. The work order confirms that the service was completed but the oven could not be calibrated at that time. There is no record of the oven being calibrated to ensure proper temperature. The Administrator indicated that following the lunch service on the specified day the sausages were overcooked, and interviews completed with the cooks (#106 and #161) confirmed the last tray of sausages was overcooked and they served it anyway. The Administrator indicated that the expectation is that cooks will monitor the food as it is cooked and not serve food that is over or under cooked. [s. 72. (3) (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 all foods and fluids are prepared, stored and served using methods which preserve taste, nutritive value and food quality, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, there is a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by the residents.

Related to logs #022045-16, #022231-16, #033257-16 and #033948-16:

Complaint log #022045-16:
An anonymous complaint was received on a specified date indicating the home does not have towels or linens, and staff are providing incontinence care with bed sheets as there are no towels available.

Complaint log #022231-16:
An anonymous complaint was received on the following day indicating there was a shortage of bed sheets, wash cloths and soap.

Complaint log #033257-16:
An anonymous complaint was received four months later indicating lack of available linens (face towels, bath towels, soaker pads and bed sheets) and complaints were made to the charge nurse and the supervisor and nothing has been done.

Complaint log #033948-16:
An anonymous complaint was received a month later indicating several weeks ago an unidentified resident could not be put to bed due to lack of available bed linens to make the bed with. A second occurred when an unidentified resident had to wait to return to bed due to lack of available bed linens. The complainant also indicated on several occasions, has had to use brown paper towel from the bathroom to dry self after morning care due to lack of available towels.

Over a two day period, a review of the available linens in the home was completed by inspector #623. Observations were made of the resident rooms, linen supply carts and storage cupboards in all six home areas as well as laundry room #1 and #2. None of the resident rooms had hand towels or face cloths for use to provide resident care throughout the day.

Review of the licensees policy HL-06-01-02 Linen Inventory Count and Appendix 2 document Linen Inventory Standards (December 2016) and the Bedding Linen & Towel inventory count sheet completed by the home on December 30, 2016 indicated that the home lacks supplies of linens and does not meet the linen inventory standards as indicated in the policy.

During an interview with the acting Director of Care (ADOC) confirmed that the home should have an adequate supply of hand towels and face cloths for all residents to use for morning care. ADOC indicated that there should be a hand towel and a face cloth on the towel bar in each resident bathroom for use thorough out the day.

During an interview with Laundry Aide (LA) #142 by Inspector # 623 (working in laundry #1) indicated that there used to be a sheet that listed the quota of linens that are supposed to sent on the carts to the unit at specific times of day but this sheet is no longer available. Laundry Aide indicated that there is never enough linens to meet the quota, so just provides what is available. Laundry Aide #142 indicated that often PSW's will come to the laundry through out the day looking for additional supplies. Laundry Aide #142 indicated that every few months there is new linen, usually face cloths and hand towels put into circulation but despite that they are always running short. LA #142 indicated supposed to supply 74 hand towels and face cloths to Aspen and Cedar units for the evening and night shift to use. Today Cedar is getting 16 face cloths and 48 hand towels, Aspen is getting 32 face cloths and 48 hand towels. This is not enough to provide care for the 34 residents in each unit. LA #142 indicated that when short of supplies, the LA notifies ESM #106.

During an interview ESM #106 indicated that at this time there are no quota sheets for the amount of linens that are to be distribute to the units. The ESM indicated that he was aware of the Policy HL-06-01-02 Linen Inventory Count and Appendix 2 document Linen Inventory Standards (December 2016). The ESM indicated that when the year end linen inventory was completed in December 2016, it was

confirmed that the home lacked supplies of linens and did not meet the linen inventory standards indicated in the policy. The ESM indicated that since that inventory was completed there was a linen order done but it would not be enough to provide the residents with the suggested amounts. ESM #106 indicated that there is no inventory on hand of linens for an emergency, that are not already in circulation. The ESM indicated that if the budget allows, he will order linens to increase the amount in circulation but he cannot exceed his budget.

During an interview the Administrator indicated that the quantity of linens on hand were not sufficient to meet the needs of the residents. The inventory of supplies available does not meet the Extendicare policy HL-06-01-02- Linen Inventory Standards Guidelines for minimum quantities. She confirmed that there is no emergency supply available of linens in the home. The Administrator indicated that she was not aware that staff and residents were lacking supplies in order to complete morning care. The Administrator confirmed that every resident should have a towel and face cloth available to them in their room for care to be completed.

In addition, related to log # 002431-17 for resident #057: PSW #129 reported unable to make the resident's bed after a shower as there were no bed linens available. (#111). [s. 89. (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 there is sufficient supply of clean linens, face cloths and bath towels always available in the home for use by the residents, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (3) The licensee shall ensure that the home's mechanical ventilation systems are functioning at all times except when the home is operating on power from an emergency generator. O. Reg. 79/10, s. 90 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the home's mechanical ventilation systems were functioning at all times except when the home was operating on power from an emergency generator.

During a tour of the home beginning on a specified date, various inspectors identified lingering offensive odours throughout the day in the corridors identified as Maple, Birch, Linden and Pine. Inspector #120 identified on the morning of a specified date, stuffy conditions and uncomfortably warm air temperatures within the same corridors and few lingering odours. Ceiling fans were running in each corridor to disperse any odours and to move the air around. Numerous residents had portable air fans operating in their rooms. The outdoor air temperature was -2 degrees Celsius.

No fresh air was being supplied to the corridors from outdoors via the supply air grilles located on the ceiling in each corridor. When checked again in the afternoon and the following morning, no air was being supplied with the exception of a slight amount of passive cold air flow from the outside. One ceiling fresh air supply grille in the Birch corridor was covered with insulation on the interior of the duct. According to the maintenance staff in the home, the fresh air supply system was shut down as the electrical heaters used to warm the outdoor air before circulation to the home were unsafe. No information or records could be provided as to when the units were shut down.

Documentation provided related to maintenance repairs and inspections conducted by an external contractor on various heating, cooling and ventilation units in the building between May and September 2016 were unclear and did not identify if the various units inspected were in the retirement home or in the long term care home. No inventory of heating, cooling or ventilation equipment could be provided for review to determine if all units were inspected. On February 1, 2017, the contractor confirmed that there were six fresh air supply units and six exhaust units for the above noted corridors. The contractor inspected all of the fresh air supply units and the exhaust units on January 31, 2017 and confirmed that all six fresh air supply units were disconnected. The licensee therefore did not ensure that the home's mechanical ventilation system was functioning at all times (except when the home was operating from an emergency generator). [s. 90. (3)]

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 the home's mechanical ventilation systems were functioning at all times except when he home was operating on power from an emergency generator, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for residents related to buffet servers with "sterno gel" fuel pots left lit and unattended with residents having access.

During the initial tour of the home by Inspector #623, the Pine Activity room was noted to be used as a temporary the dining room for Pine residents as the home was experiencing a respiratory outbreak. The door to the activity room was noted to be propped open and contained two carts with four “buffet serving trays” with hot water in them and underneath the buffet trays had "sterno gel" fuel pots two of which were lit. The warming trays were hot to the touch and water in the trays was noted to be steaming, but no food present. There were no staff present in the room and two residents were observed walking by the room.

At that time, Inspector #623 interviewed Housekeeper #103 who was passing by the room. The housekeeper confirmed that the door should be locked when no one was in the room and that residents should not have access to the hot food servers. The Housekeeper then proceeded to lock the room.

The Administrator was notified by Inspector #623 of the observations in the Pine Activity room. Administrator confirmed that this room was being used as a temporary dining room for the Pine unit residents and that the room should be locked if there were no staff present. The Administrator indicated that the "sterno fuel pots" should not be left lit and unattended.

The licensee failed to ensure that the home is a safe and secure environment for the residents. [s. 5.]

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Related to log # 002431-17:

A Critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect that occurred over a two day period at specified times. The CIR indicated resident #061 (who is cognitively well) reported witnessing staff to resident neglect by PSW #129 towards resident #057 (who is cognitively impaired) on two separate days.

Review of the current written care plan for resident #057 indicated the resident was at risk for skin breakdown related to incontinence and is cognitively impaired. The interventions indicated the resident will not call for toileting and staff are to check and change the resident every 2-3 hours.

Review of the home's investigation indicated PSW #129 reported to the acting DOC that assistance was provided with toileting resident #057 on the two specified days twice during their shift, the resident would call for further assistance with toileting as needed. PSW #123 reported assisting PSW #129 only once on both specified days with toileting and indicated resident #057 required more frequent toileting due to level of incontinence. Resident #057 was not provided care according to the plan of care related to toileting as indicated in the plan of care. [s. 6. (7)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, related to sleep and rest patterns.

Related to log # 002520-17:

A critical incident report (CIR) was submitted to the Director on a specified date for

an alleged staff to resident physical abuse that occurred at a specified time. The CIR indicated program staff (PS #171) had reported resident #046 alleged being rough handled earlier that same day during care and had been occurring over the last two weeks to RN Manager #118 the same day. The CIR did not indicate which staff was involved with the allegation. The CIR indicated the outcome of the investigation was pending.

Review of the licensee's investigation indicated PSW #172 was involved in the allegation and the PSW was unaware of the residents sleep and rest preferences.

Review of the current written care plan for resident #046 indicated the under bed mobility: staff to monitor for signs and symptoms of pain when getting resident in and out of bed and under sleep and rest patterns: gets am care provided at a specified time. The plan of care was not provided to the resident according to the plan, related to sleep and rest patterns. [s. 6. (7)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure,

strategy or system instituted or otherwise put in place is complied with.

Related to Medication management system, Under O.Reg.79/10, s.114(3)The written policies and protocols must be, (a) developed, implemented, evaluated and updated in accordance with evidence-based practises and, if there are none, in accordance with prevailing practises

The Licensee failed to implement its "Medication Management Policy" (# RC-06-05 -07 and last updated in June 2016) related to administration of eye drops to resident #057. The policy indicated “scheduled medication will be administered according to standard medication administration times. Medication should be given within the recommended time frame, 60 minutes prior to and 60 minutes after the scheduled medication time.”

Review of resident #057 current Medication Administration Record (MAR) revealed two physician prescribed eye drops related to diagnoses to be provided at two specified times and intervals.

A review of the medication administration audit report for the resident revealed that on four dates in a specified month, at a specified time, the morning dose was administered between 88 and 129 minutes after the scheduled administration time, by RPN # 130 & #138. The afternoon dose of both eye drops, was administered between 80 and 143 minutes after the scheduled administration time on eight specified dates during the same month period by a range of different nurses.

In interviews conducted by Inspector #624 with RPN #130, RPN #163 and RPN #162 (who had administered the 1600 hours eye drops on specified dates), all indicated that they had administered the medication at the times entered on the medication audit report. They all also indicated that the home’s expectation is that medication should be administered 60 minutes prior to and 60 minutes after the scheduled medication time. They all indicated that in the event that a medication is administered late for any reason, an explanatory medication note is to be documented in the progress notes.

A review of resident #057's progress notes, did not reveal any entry on the dates identified above.

The Acting Director of Care, when interviewed by Inspector #624 on the home’s expectation on medication administration, she indicated as well that medication

should be administered 60 minutes prior to and 60 minutes after the scheduled medication time. She added that if for any reason a scheduled medication is not administered 60 minutes before and 60 minutes after the scheduled medication time, an explanatory note is to be documented in the progress notes for the concerned resident.

The licensee failed to comply with the Medication Management Policy # RC-06-05-07, by administering a scheduled medication 80 to 143 minutes after the scheduled administration time. [s. 8. (1) (b)]

WN #14: 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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

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

Review of the licensee"s policy "Zero Tolerance of Resident Abuse and Neglect" (RC-02-01-01) (April 2016) indicated:
immediately respond to any alleged or suspected incident of resident abuse or neglect.
-promptly and thoroughly investigate all alleged or reported incidents.
-identify and correct situations where abuse, neglect and /or mistreatment can occur.

-immediately respond to any alleged or suspected incident of resident abuse or neglect.

Related to log #001738-17:

Critical Incident Report (CIR) was submitted to the Director on a specified date for an alleged staff to resident verbal and physical abuse that was reported to Inspector #626 during the inspection. Inspector #626 reported the allegations to the Administrator on the same day. Resident #010 indicated the day before, at a specified time, two staff were rough when providing care resulting in pain. The resident also indicated that PSW #139 and PSW #149 made inappropriate comments towards the resident. The resident also indicated the incidents were reported to RPN #120 the following morning (the day it was reported to Inspector #626).

An interview with RPN #120 by Inspector #626 confirmed the resident reported allegations of verbal abuse by PSW #139 and #140 the day after they occurred but was unable to recall when the allegation was received. The RPN indicated no allegation of physical abuse were made at that time. RPN #120 indicated that the resident had requested the allegations not be reported and the RPN should have reported it.

An interview at two separate dates with the Administrator indicated that RPN #120 did not report the incident until the investigation was initiated two days later. The Administrator indicated that it is the expectation that staff report incidents of abuse immediately to their RN supervisor.

The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with as RPN #120 failed to immediately report the incident of verbal abuse until one day after it was reported by the resident. [s. 20. (1)]

2. Related to log #020568-16:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident verbal abuse. The CIR indicated at a specified time, resident #015 was observed being verbally abusive towards resident #053 by PSW #151 and PSW #152, who did not intervene. RPN #132 also witnessed the incident and intervened. RPN #132 reported a complaint of staff to resident neglect the

same day as staff failed to intervene regarding this incident.

A off-site enquiry was made to the Administrator requesting the outcome of the licensee's investigation into the allegation as the CIR was not updated to provide this information. The information was not provided by the home. An inspection was then initiated as a result six months later, and the Administrator was asked for the home's investigation at that time to determine the outcome of the investigation. One staff interview was provided to the inspector at that time but no outcome of the investigation.

Review of the home's investigation documentation, review of resident health records, and interview of staff indicated the licensee's policy was not followed related to the investigation process as there was no documented evidence to indicate the home promptly and thoroughly investigated the alleged or reported incidents. There was also no documented evidence to indicate the home corrected situations where abuse can occur as per the licensee's policy. [s. 20. (1)]

3. Related to log # 002431-17:

Critical incident report (CIR) was received by the Director on a specified date for an alleged staff to resident neglect that occurred over a two day period at specified times. The CIR indicated resident #061 (who is cognitively well) had reported witnessing resident #057 (who is cognitively impaired) being neglected over a two day period by PSW #129.

Interview with Administrator and acting DOC by Inspector #111, indicated PSW #129 (involved in the allegation of neglect) and resident #061 (who reported the allegation), were interviewed two days after the allegations were reported and determined the allegations were unfounded. The Administrator indicated the home determined that PSW #129 had provided proper care to resident # 057 and some of the care could not be provided due to lack of supplies available at the time. The following day, the Administrator indicated she forgot that she had also interviewed three other PSW's the day of the allegations but did not document the interviews. The Administrator concluded the investigation and indicated the allegations were unfounded.

Review of the licensee's investigation documentation, interview of staff, and review of resident #057 health record, indicated a complaint was received by resident #061 regarding an allegation of staff to resident neglect that occurred over a two

day period towards resident #057 by PSW #129. There was no documented evidence the investigation was promptly and thoroughly investigated and staff interviews were not documented as per the licensee's policy. There was no documented evidence indicating corrective actions were taken related to the resident not being provided proper care despite the resident's plan of care providing clear direction related to those care needs or any corrective actions related to the lack of supplies. [s. 20. (1)]

4. Related to log # 027318-16:

The Ministry of Health after hours was called on a specified date to report an incident of injury of unknown cause to resident #045. A CIR was not submitted at that time. A critical incident report (CIR) was received five months later as a result of the off-site enquiry. The CIR indicated that four months earlier (on a specified date and time) RPN #117 noted an injury to a specified area on resident #045 and suspected rough handling by a staff or other resident. The CIR indicated the investigation was still pending.

Interview with Administrator by Inspector #111 and request for the outcome of the investigation indicated the investigation was not yet completed (five months later).

The licensee's policy was not complied with when an allegation of resident physical abuse was made regarding unexplained injuries to a specified area was not promptly and thoroughly investigated. [s. 20. (1)]

5. Related to log #033626-16 & 034927-16:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect that occurred on the same day at a specified time. The CIR indicated the SDM of resident #049 brought forth complaints to the RN Manager #118 regarding improper care provided to resident #049 and would be submitting a written complaint regarding the incidents. The CIR indicated nine days later, the SDM provided the written complaint regarding the incidents that occurred nine days earlier and requested not to have the same PSW assigned to providing care for the resident.

Review of the written complaint from the SDM of resident #049 indicated: nine days earlier, on a specified shift, the resident reported PSW #144 had neglected and provided improper care. The SDM indicated the allegations were reported to

the acting DOC the same day. The SDM reported PSW #173 and RPN #137 were also aware of the allegations the same day they occurred.

Interview with acting DOC and RN Manager #118 by Inspector #111, confirmed the home was aware of allegations of neglect on the day they occurred and the day after they occurred. The investigation was not promptly and thoroughly investigated as per the licensee's policy as the investigation was not initiated until four days later and not all staff and resident who had knowledge of the incident were interviewed regarding the incident. There was no documented evidence to indicate the home corrected situations where abuse, neglect and /or mistreatment can occur as per the licensee's policy. [s. 20. (1)]

6. Related to log #002520-17:

A critical incident report (CIR) was submitted on a specified date for an allegation of staff to resident physical abuse that occurred on the same day at a specified time. The CIR indicated a program staff #171 had reported to RN Manager #118 that resident #046 had reported being rough handled and was upset regarding the incident.

Review of the home's investigation documentation indicated resident #046 was upset and weepy after reporting the incident. The program staff #171 indicated the SDM was also present and reported the incident had been occurring over the last weeks. The home's investigation determined PSW #172 was involved in the allegation and when interviewed, confirmed that resident #046 was not provided care as per the resident written plan of care related to sleep patterns and the resident had requested to remain sleeping. Review of the resident's current written plan of care related to sleep patterns and preferences indicated the care was not provided to resident #046 as indicated in the plan. There was no other staff interviewed regarding the incident and no further actions taken.

Interview with the Administrator by Inspector #111 indicated the outcome of the investigation was unfounded and no further actions were taken to prevent a recurrence.

The licensee's Zero Tolerance of Abuse and Neglect policy was not complied with as there was no documented evidence that despite the plan of care not provided to the resident as per the resident's preferences related to sleep and rest patterns and the resident being upset with how care was provided, there was no further

action taken by the home to correct the situation where improper care occurred as per the licensee's policy. There was also no documented evidence the home thoroughly investigated the allegation of staff to resident rough handling as only the person interviewed was the staff involved in the allegation. [s. 20. (1)]

7. The licensee has failed to ensure the policy to promote zero tolerance of abuse and neglect of residents shall:
(e) contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents
(f) set out the consequences for those who abuse or neglect residents.

Review of the home's policy "Zero Tolerance of Resident Abuse and Neglect" (RC-02-01-01) revised April 2016 indicated under procedures on page 2 of 7:
-promptly and thoroughly investigate all alleged or reported incidents.
-Identify and address root causes using quality improvement methods and tools and interdisciplinary care planning strategies.
-Identify and correct situations where abuse, neglect, and or mistreatment can occur.
-Promptly investigate resident to resident altercations, complaints and unexplained bruising or injuries to determine root cause and put in place measures to prevent recurrence.

The Licensee's "Zero Tolerance of Abuse and Neglect" policy:
- did not contain procedures for investigating and responding to alleged, suspected or witnessed incidents of abuse and/or neglect of a resident by "a staff member",
-did not set out the consequences for those who abuse and/or neglect residents.
-did not provide procedures for "preventing" staff to resident abuse and/or neglect.
-did not include how staff were to document when any alleged, suspected or witnessed incidents of abuse and/or neglect is identified by a staff member and what assessment and care was to be provided to the resident.
-the policy references the home's "Complaint and Customer Service" policy which contained procedures for investigating all complaints (including abuse and/or neglect) but this policy was also not complied with. [s. 20. (2)]

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Related to log # 027318-16:

The Long Term Care Emergency after hours was contacted on a specified date to report resident #045 had an injury to a specified area and suspected rough handling from a staff or resident". A CIR was not submitted to the Director until four months later and indicated the investigation was still pending.

Interview with the Administrator by Inspector #111 regarding the outcome of the investigation, indicated the investigation was still ongoing. The Administrator indicated the investigation was started by the acting DOC four months later when the CIR was submitted. [s. 23. (1) (a)]

2. Related to log # 023595-16:

A critical incident report (CIR) was submitted on a specified date for an allegation of resident to resident sexual abuse. The CIR indicated the incident occurred over a two day period at specified times between resident #043 and #044. The CIR indicated both resident's were cognitively impaired and neither resident was able to provide consent for sexual behaviour.

Interview with Administrator by Inspector #111 regarding the incident indicated an investigation was completed into the incident but she was unable to locate the investigation documentation. [s. 23. (1) (a)]

3. Related to Log #026513-16:

Critical Incident Report (CIR) was submitted by the Director on a specified date for an allegation of neglect of care of resident #054. The CIR indicated on the same day, the Substitute Decision Maker (SDM) of resident #054 voiced concerns to the Social Worker regarding allegations of improper care.

Review of the CIR and the licensee's Client Feedback Log (completed by Social Worker approximately one month later) in relation to the allegations of improper care indicated the acting DOC "spoke with front line staff regarding customer services to residents and how to respond to resident/family concerns". The Administrator indicated to Inspector #570 that she confirmed with the Acting DOC that an investigation was not completed. There was no documented evidence that an investigation was initiated or completed into the allegation of improper care or neglect of resident #054.(570) [s. 23. (1) (a)]

4. Related to log # 002431-17:

A critical incident report (CIR) was submitted to the Director on a specified date related to an alleged staff to resident neglect that occurred on over a two day period at specified times. The CIR indicated resident # 061(who is cognitively well) had reported that resident #057 had been neglected by PSW #129 over a two day period.

Interview with the Administrator by Inspector #111 and request for the home's investigation documentation into the allegation of staff to resident neglect towards resident #057 indicated two interviews (resident #061 and PSW #129) were completed two days after the allegations were reported. The Administrator

indicated at that time no other interviews were completed and the investigation was concluded as 'unfounded'. The following day, the Administrator then provided an interview of PSW #123 that was completed nine days after the allegation was reported and as a result of the inspection. The Administrator also indicated she had also interviewed three other PSW's (#140, #145 & #170) the day of the allegation but did not document the interviews. [s. 23. (1) (a)]

5. Related to log # 002520-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse that occurred on the same day at a specified time. The CIR indicated program staff #171 had reported in writing to RN Manager #118 that resident #046 had reported being rough handled earlier that morning during care. The program staff also indicated the SDM of resident #046 also reported it had been happening for two weeks.

Review of the home's investigation documentation indicated the allegation of staff to resident rough handling was reported immediately to RN Manager #118, the allegation identified PSW # 172 involved in the allegation and the resident was upset and weepy when reporting the allegation. RN Manager #118 did not report the allegation until the following day and then notified the police and interviewed the resident's SDM. PSW #172 was not interviewed until two days later regarding the allegation.

The investigation was not immediately initiated as the investigation did not start until the day after the allegation was made of staff to resident rough handling. [s. 23. (1) (a)]

6. Related to log # 033626-16 & # 034927-16:

A critical incident report (CIR) was received on a specified date for an allegation of staff to resident neglect that occurred on the same day and at a specified time. The CIR indicated the SDM of resident #049 brought forth complaints to the RN Manager #118 regarding improper care towards resident #049. The CIR indicated the resident has difficulty communicating due to diagnosis. The CIR indicated the SDM would be submitting a written complaint regarding the incidents. The CIR indicated seven days later, a written complaint was received by the SDM regarding the allegations. The CIR indicated the SDM requested not to have the same PSW providing care to the resident.

Review of the written complaint from the SDM of resident #049 indicated nine days earlier, on a specified shift, the resident reported PSW #144 had neglected and/or provided improper care throughout the specified shift. The SDM reported PSW #144 had provided improper care resulting in discomfort to resident #049 to the acting DOC the same day the incident occurred (nine days earlier). The SDM also reported the allegations to RN Manager #118 the following day. The SDM indicated that PSW # 173 and RPN #137 were aware of allegations of neglect the same day the incident occurred.

Interview with acting DOC and SDM by Inspector #111 confirmed the home was aware of allegations of improper care and/or neglect on the day the incidents occurred and the investigation was not initiated until four days later. [s. 23. (1) (a)]

WN #16: 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 failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: 1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.

Related to log # 033626-16 & # 034927-16:

A critical incident report (CIR) was submitted on a specified date for an allegation of staff to resident neglect that occurred the same day at a specified time. The CIR indicated the SDM of resident #049 brought forth complaints to the RN Manager #118 regarding improper care provided to resident #049 on the same day.

Review of the home's investigation and interview of staff indicated the SDM reported the allegations the day before the report to the Director, to the acting DOC. and the Director was not notified until the following day. [s. 24. (1)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible, strategies are developed and implemented to respond to these behaviours, where possible, and actions are taken to respond to the needs of the resident, including assessment, reassessments and interventions, and that the resident's responses to the interventions are documented.

Related to log # 023595-16:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged resident to resident sexual abuse. The CIR indicated the incident occurred the day before at a specified time when resident #043 and resident #044 were found demonstrating sexually inappropriate behaviour in resident #044 room. and staff did not intervene. Approximately three hours later, resident #043 and resident #044 were still in resident #044 room and observed demonstrating sexually inappropriate responsive behaviours. Resident #043 was then removed from the room. The CIR indicated both residents were cognitively impaired and

neither resident was able "to provide consent for sexual behaviour". The CIR indicated 1:1 staffing was put in place and referral to Behavioural Supports Ontario (BSO) as a result.

Observation of resident #043 on a specified date by Inspector #111 indicated the resident was cognitively impaired and independently mobile with use of a mobility aide. Resident #044 is no longer in the home.

Review of the progress notes for resident #043 and #044 related to sexually inappropriate responsive behaviours and/or sexual abuse over a three month period indicated:
-On a specified date, the initial incident occurred (as indicated in the CIR) and the SDM of resident #044 indicated "was not in agreement" with the relationship between both residents. Resident #043 was placed on dementia observation system (DOS every 15 minute checks) and not on 1:1 monitoring as per the CIR.
-Approximately ten days later, resident #043 continued on DOS every 15 minute monitoring. The resident was observed demonstrating sexually inappropriate behaviours towards resident #044. Resident #043 was also requesting inappropriate sexual arrangements with resident #044. Both residents continued to sit together near the nursing station or in the lounge. Resident #043 stated "want to get married".
-The following day, resident #043 was observed demonstrating sexually inappropriate behaviour towards resident #044 and was redirected to bed. Later in the shift, both residents were observed seeking each other and demonstrating sexually inappropriate behaviours. Resident #043 was redirected.
-Two days later, resident #043 was demonstrating sexually inappropriate behaviour in resident #044 room. The RN, DOC and physician were also notified and medication changes were received for resident #043. 1:1 staffing was authorized by DOC at this time. Resident #043 continued on DOS.
-The following day, resident #043 was sitting in front of resident #044 room seeking out the resident. The BSO team indicated resident #043: "remains in program, has increased responsive behaviours by way of increased agitation when staff attempt to re-direct from unspecified co-residents". BSO indicated resident #043 "is losing sleep at times" due to seeking unspecified co-residents, and other residents reporting resident #043 & #044 demonstrating sexually inappropriate behaviours in the dining room and threatening remarks made to other residents by resident #043. The BSO indicated resident #043 remained on DOS and current interventions not effective, recommended a room change. Later the same day, resident #043 was observed seeking resident #044. The staff administered medication to resident

#043 and “Remains on 1:1 intervention this shift”.
-The following day, resident #043 was seeking out and attempting to enter the room of an unidentified co- resident and was redirected. Later in the evening, resident #043 was seeking out resident #044 and “encouraging" resident #044 not to take medications. 1: 1 monitoring continued. Both residents were observed sitting in the corridor demonstrating sexually inappropriate responsive behaviours for remainder of evening with no redirection.
-The following day, resident #043 remained on DOS and was observed demonstrating sexually inappropriate responsive behaviours with resident #044.
-Two days later, during lunch, resident #043 began calling resident #044 to join the resident's table. Resident #044 attempted to go to resident #043 table when staff intervened. BSO staff were notified and required 4 staff to redirect resident #044 back to own table. BSO indicated resident #043 & #044 were demonstrating sexually inappropriate behaviours and were posing a safety risk to other residents. Resident #044 had to be moved to another dining room to complete meal. Resident#044 did not eat or drink well at the meal as a result. The SDM of resident #044 was contacted and discussed possible relocation to another unit due to “friendship with co-resident in the unit” and “increased behaviours". The SDM agreed with room transfer and resident #044 was transferred to a different unit. Later the same day, resident #043 was noted sitting with resident #044 near nursing station. The Administrator assisted staff with redirection of resident #043 to allow [resident #044] to complete the dinner meal. Resident #044 became more aggressive and BSO staff were called to assist and relocated resident #044 to another dining room. The SDM of resident #043 was contacted and informed of the intervention that was initiated “just for this shift” by having to put resident #044 in a different dining room. Resident #043 was later observed sitting in hallway with resident #044 demonstrating sexually inappropriate behaviour.
-Five days later, resident #043 remained on DOS and continued “to seek out" unspecified co-residents. The resident was now seeking out another unidentified co-resident. The resident was also found in an unidentified co-resident's room attempting to get into the resident's bed.
-The following day, the BSO Team met with the physician, pharmacy and RN to review behaviours for resident #043 and noted the resident behaviours were increasing (more verbally and physically aggressive with staff, exhibiting paranoid behaviours, and verbally aggressive with roommate). Resident #043 was “started on a DOS to closely monitor resident's behaviours". During the evening, resident #043 was noted to wander throughout the shift seeking resident #044.
-The following day, resident #043 was awake during the night, confused, wandering different units and asking staff for resident #044. Later in afternoon,

resident #043 was sitting and talking outside of the doorway of [unidentified] co-resident, asking the resident to come out into the corridor. Resident #043 also continued asking staff for the room number of resident #044.
-Three weeks later, resident #043 continued to seek unspecified co-resident's, and was observed sitting in lounge with an [unidentified]co- resident through out the shift.
-Four days later, the BSO Team indicated: resident #043 had no reports of behaviours in the last month and discharged from BSO program.

Interview with RPN #132 & #133 (BSO) by Inspector #111,there was no referral to BSO regarding the initial incident of sexual abuse that occurred (as indicated on CIR), however, they read about the incidents and placed both residents in the BSO program as a result. The BSO staff indicated the family of resident #044 was upset about the initial incident between resident #043 & #044 and had requested "they be kept apart". The RPN's indicated resident #043 was then placed on 1:1 supervision as a result. Both RPN's indicated resident #043 and #044 would be seen demonstrating sexually inappropriate behaviours. The RPN's indicated the PSW's were to complete DOS every 15 minute monitoring record for resident #043 while on the program. The RPN's indicated resident #044 was then moved to another unit and the sexually inappropriate responsive behaviours between resident #043 & #044 discontinued so resident #043 was discharged from BSO. Both BSO staff were unaware the sexually responsive behaviours demonstrated by resident #043 continued towards other co- residents after resident #044 was relocated to another unit.

Interview with RN #035 by inspector #111, regarding any current responsive behaviours demonstrated by resident #043 and indicated "two weeks ago, a family reported witnessing" resident #043 demonstrate sexually inappropriate responsive behaviour and/or sexual abuse towards the resident. The RN was unable to recall who the recipient resident was. The RN was not aware of any prior sexually inappropriate responsive behaviours demonstrated by resident #043 but indicated resident #043 previously "believed" was married to resident #044, would seek the resident out, and they would just walk together, but no sexual activity". The RN indicated resident #044 was moved to another unit as the family of resident #044 was not agreeable to the relationship. The RN indicated the behaviour stopped once the male resident was relocated until the recent report. The RN was not aware of the resident having inappropriate sexual behaviours with any other male residents. Review of the progress notes of resident #043 had no documented evidence of the incident reported by the family member.

Review of the written care plan (at time of incidents) for resident #044 indicated cognitive impairment and the resident was recently relocated to a different room. Under socially inappropriate behaviour: the resident was witnessed demonstrating sexually inappropriate behaviour towards an (unidentified) co-resident [this incident was different from incident reported on CIR and had no documented evidence in progress notes] and sexually inappropriate with (unidentified) female co-residents. Interventions included: if becoming inappropriate with female co-resident, distract the resident and remove from the situation, monitor the resident to ensure does not have female co-residents in room, do not leave resident alone with a female co-resident, and currently on increased observation related to female co-resident in bed (incident on CIR). There was no indication what the sexually inappropriate behaviours were, which female residents they were directed towards, or how the staff were to monitor or frequency of monitoring.

Review of the written care plan for resident #043 (updated the day after incident on CIR) indicated resident #043 "believes she/he is in a long term romantic relationship with a male co-resident". Co-resident's family do not agree with the relationship. The care plan was updated nine days later and included monitor resident every shift and report to charge nurse for any inappropriate mood and behaviour. The interventions were updated three weeks later and included: monitor behaviour episodes and attempt to determine underlying causes, often becomes upset if redirected from male co-residents, validate the resident's feelings and re-direct the conversation, monitor for increased behaviour, and initiate behaviour tracking, and in BSO program.

The written plan of care for both resident #043 & #044 did not indicate the triggers and strategies to manage the sexually inappropriate responsive behaviours, and did not indicate which female/male resident(s) they were demonstrating sexually inappropriate behaviours towards. Resident #043 had demonstrated inappropriate sexual responsive behaviours towards more than one male resident and this trigger was not identified (nor were the male residents identified); The plan of care did not clearly indicate what the “sexually inappropriate” behaviour included for either resident despite the progress notes for both residents indicating, seeking out males (resident #043), and describing the behaviours of both residents. There was no documentation in resident #044 health record related to the sexually inappropriate incident referred to in the written plan of care of resident #044, to indicate who the recipient resident was, or when this occurred. The incident with resident #043 as reported by a family member of an unidentified resident to RN #035 (during

interview) was also not identified in the health record of resident #043 to indicate when it occurred and towards whom. The strategies to manage the sexually inappropriate responsive behaviours was also not clear as there was no indication how staff would ensure the residents would be monitored, what "increased observation" included, and have they would ensure specified co-resident was not in the residents' room. The observation period was unclear and sometimes resident #043 was placed on 1:1 and other times on DOS (every 15 minute observations). The sexually inappropriate responsive behaviours were accepted by some staff as "a relationship" and allowed to occur despite directions to intervene when they occurred. Other strategies were not considered for both resident #043 & #044 when current strategies were not effective and one strategy (relocating resident #044 to another unit) was not considered until after several more incidents occurred, despite the responsive behaviour negatively affecting both residents, and as requested by the SDM of resident #044. There was no indication of a referral to psychogeriatric services and the resident was discharged from the BSO program despite the sexually inappropriate responsive behaviours continuing for resident #043. [s. 53. (4)]

WN #18: 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 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

Review of the licensee's Weight Change Program policy (#RESI-05-02-07) on page 1 of the policy, under Procedures indicated registered nursing staff:
1.Compare to previous month's weight; and any weight with a 2.5 kg difference from the previous month requires a re-weigh. Registered staff is to direct care staff to re-weigh the resident.

Related to Log #026513-16:

A Critical Incident Report (CIR) was submitted by the Director in relation to an allegation of neglect of care of resident #054 that occurred on a specified date. The CIR indicated that on the same day, and at a specified time, the Substitute Decision Maker (SDM) of resident #054 voiced concerns to the Social Worker regarding improper care and included concerns related to weight loss.

Review of clinical records for resident #054 indicated when the resident was admitted to the home, the resident was assessed at a moderate nutritional risk.

Resident #054's weights were reviewed over a six month period and noted a significant weight change of 4.7 kg between two of the specified months and a -9.75% weight change in last month period.

Inspector #570 interviewed the home's Registered Dietitian (RD #157) regarding resident's weight variances from the previous month. The RD stated the expectation was that if the resident's weight differs by 2.2 kg or more from the previous month's weight, then a re-weigh should be completed. The RD indicated that resident #054 should have been reweighed when the resident's weight dropped by 4.7 kg.(570) [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. Related to Resident #007:

During an interview with Inspector #626 and resident #007's SDM, the SDM

expressed concerns that the resident had lost weight because the resident was not eating, and that if the resident does not go to the dining room for meals, the SDM was concerned that staff would not assist the resident to the dining room.

Review of resident #007 weight over a six month period indicated on a specified month, the resident had a weight variance of approximately 4 kg between two months. Progress note by the Dietitian during the same time period indicated a 10% weight loss over six months.

Inspector #626 interviewed the home's Registered Dietitian (RD #167) regarding the expectations when a resident's weight varies from the previous month. The RD stated the expectation was that if the resident's weight differs by 2.5 kg or more from the previous month's weight, then a re-weigh should be completed. The RD indicated that resident #007 should have been reweighed when the resident's weight decreased

In an interview with RPN #101, the RPN indicated that the resident should have been reweighed when the weight was decreased.

Interview with the Administrator by Inspector #626 confirmed that when a resident is weighed and determined to have significant weight loss, the resident must be re-weighted right away.

The resident was not re-weighed when there was a significant decrease in the resident's weight and actions were not taken and the outcomes evaluated.(626) [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #19: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to ensure the resident satisfaction survey results were made available to the Residents Council in order to seek the advice of the Council about the survey, and the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents Council.

During an interview with Resident Council President (RCP) by Inspector #623, the RCP indicated that the resident satisfaction survey was completed annually in the home, however, the results of the resident satisfaction survey were not communicated to the Resident's Council in 2016.

Interview with the Administrator indicated the 2015 resident satisfaction survey results were not communicated in 2016 to the Residents Council.

The licensee failed to document and make available to the Residents' Council the results of the satisfaction survey in 2015. (623)[s. 85. (4) (a)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee failed to ensure that the licensee's written policy to promote zero tolerance of abuse and neglect of residents:
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate.

Review of the home's policy "Zero Tolerance of Resident Abuse and Neglect" (RC-02-01-01) revised April 2016 indicated under procedures on page 2 of 7:
-identify and address root causes using quality improvement methods and tools and interdisciplinary care planning strategies.
-identify and correct situations where abuse, neglect, and or mistreatment can occur.
-promptly investigate resident to resident altercations, complaints and unexplained bruising or injuries to determine root cause and put in place measures to prevent recurrence.

This policy does not provide specific procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected and does not provide specific procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Related to log # 027318-16:

The Long Term Care Emergency after hours was contacted on a specified date to report resident #045 had an injury to a specified area and suspected rough handling from a staff or resident. A CIR was not submitted at that time until four months later as a result of an off-site enquiry completed by Inspector #111. The CIR indicated the SDM was not notified of the incident.

Interview with the Administrator by Inspector #111 indicated the SDM was not notified of the incident. [s. 97. (1) (a)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the verbal complaints made to licensee or a staff member concerning the care of a resident or operation of the home: has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately.

Related to log # 034747-16:

On a specified date, a complaint was received from resident #012's Substitute Decision Maker (SDM) related to improper care of resident #012.

During a telephone interview with the complainant on a specified date, it was indicated to Inspector #166, resident #012's SDM came to the home to visit the resident and met with the Acting DOC, the physician, RN #118 and RPN #101. The SDM indicated, at that meeting, the complaint was brought forward related to improper care of resident #012.

The SDM indicated no response was received by the home related to the concerns brought forward.
Review of the licensee's documentation does not provide any evidence that a response to the improper care concerns expressed by the SDM was provided to the SDM.

Review of email correspondence (approximately one month later) from the Social Worker addressed to RN #118, indicated the SDM for resident #012 approached the Social Worker to discuss care concerns.The content of the email indicated that the SDM was planning to discharge the resident due to the improper care concerns.

Interview with RN #118, concerning the email from the Social Worker, by Inspector #166 indicated could not recall receiving the email and therefore did not respond to the SDM related to the improper care concerns of resident #012 . [s. 101. (1) 1.] (166)

2. The licensee has failed to ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

Related to log# 034747-16:

A complaint was received from resident #012's SDM on a specified date related to improper care for resident #012.

Telephone interview with the complainant indicated the improper care concerns for resident #012 were reported to the ADOC, the physician, RCAM#118 and RPN#101 approximately two months prior.

Review of email correspondence approximately one month after initial verbal complaint, the Social Worker addressed to RN #118, indicated the SDM for resident #012 approached the Social Worker to discuss improper care concerns and the family was planning to discharge the resident as a result.

Review of the licensee's policy "Complaints and Customer Service" revised April 2016 indicated on page 3 of 6, under Investigation:
-each contact with the complainant should be recorded on the contact log by the person making the contact (appendix 4)

Review of the licensee's complaint log during the same two month period did not have any documented evidence that resident #012's SDM verbal complaints related to improper care of resident #012, were received on either of the two separate dates they were received. (166) [s. 101. (2)]

3. Related to log # 033626-16 & #034927-16:

A verbal compliant was provided to the acting DOC on a specified date related to improper care provided to resident #049 the same day the incident occurred.
A written complaint letter was also received by the home nine days later, from the SDM of resident #049 indicating allegations of staff to resident neglect and improper care by PSW #144. The letter indicated the incidents occurred nine days prior on a specified shift.

Interview with Social Worker(SW) indicated she was responsible for maintaining the home's complaint log and enters all verbal and written complaints that are received once the investigations are completed. The SW was not aware of a verbal complaint received by the home on a specified date or a written complaint received nine days later regarding allegations of staff to resident improper care and neglect towards resident #049.The SW indicated the acting DOC or Administrator usually

provides her with the verbal or the written complaints.

Review of the home's complaint log for the specified time period did not have any documented evidence of a verbal or written complaint received by the SDM of resident #049 related to staff to resident improper care and neglect. [s. 101. (2)]

4. Related to log # 002520-17:

A verbal complaint was made on a specified date regarding staff to resident rough handling towards resident #046 and there was no documented evidence on the home's complaint log regarding this complaint.

Interview of the SW indicated she was not aware of this verbal complaint and did not log the complaint in the complaint log. [s. 101. (2)]

WN #23: 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. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident: (ii) names of any staff members or other persons who were present at or discovered the incident.

Related to log # 002431-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect that occurred the day before and the same day the CIR was submitted, at a specified time. The CIR indicated resident #061 (who is cognitively well) had reported that resident #057 had been neglected by PSW #129. The CIR did not indicate any other staff were present at the time of the incident.

Review of the licensee's investigation, documentation and interview with

Administrator and acting DOC indicated that PSW # 123, 140, #145 & #170 had also been interviewed related to the allegation as they were present or working at the time of the incident. [s. 104. (1) 2.]

2. Related to log # 002520-17:

A critical incident report (CIR) was submitted on a specified date for an allegation of staff to resident physical abuse that occurred on the same day at a specified time. The CIR indicated a program staff #171 had reported to RN Manager #118 that resident #046 had reported being rough handled during care. The CIR did not indicate which staff was involved with the allegation.

Review of the home's investigation and interview of staff indicated that PSW #172 was involved in the allegation. The name of PSW #172 who was involved in the allegation was not identified in the CIR. [s. 104. (1) 2.]

3. Related to log # 033626-16 & # 034927-16:

A critical incident report (CIR) was submitted on a specified date for an allegation of staff to resident neglect that occurred on the same day at a specified time. The CIR indicated the SDM of resident #049 brought forth complaints to RN Manager #118 regarding improper care provided to resident #049.

Review of the licensee's investigation, documentation and interview of staff by inspector #111 indicated RPN #137, PSW # 173, PSW #174 and PSW #175 had been present but were not identified in the CIR. [s. 104. (1) 2.]

4. The licensee has failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

Related to log # 027318-16:

The Ministry of Health and Long Term Care (MOHLTC) after hours was called on September 4, 2016 to report resident #045 had an injury to a specified area and suspected rough handling by a staff or from a resident. A CIR was not submitted at that time. A critical incident report (CIR) was submitted four months following the incident. [s. 104. (2)]

5. The licensee has failed to ensure that if unable to provide a report within 10 days, that a preliminary report is made to the Director within 10 days, followed by a final report within the time specified by the Director (in 21 days unless otherwise specified by the Director).

Related to log #023595-16:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged resident to resident sexual abuse. The CIR indicated the incident occurred the day before at a specified time when resident #043 and resident #044 were found in resident #044 room demonstrating sexually inappropriate behaviour. Approximately three hours later, resident #043 was still in resident #044 room and both residents were observed demonstrating sexually inappropriate responsive behaviours. Resident #043 was then removed from the room. The final report to the Director was not submitted indicating the outcome of the licensee's investigation.

Interview with the Administrator indicated four months later, she was unaware the finale report to the Director was not submitted to indicate the outcome of investigation. [s. 104. (3)]

6. Related to log #020568-16:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect that occurred the same day. The CIR indicated at a specified time, resident #015 was observed being verbally abusive towards resident #054 . The incident was witnessed by PSW # 151 and #152 who did not intervene. RPN #132 then witnessed the incident and intervened. The CIR indicated the investigation was initiated but the final report was not submitted to the Director with the outcome of the licensee's investigation to date. [s. 104. (3)]

7. Related to log # 034777-16:

Review of critical incident report (CIR) documentation indicated that on a specified date, the Substitute Decision Maker (SDM) for resident #012, voiced concerns to the licensee related to the improper wound care management for resident #012.

Interview with the Acting Director of Care and the Administrator on a specified date indicated that a final report had not been submitted to the Director within the 21

days as specified by legislation. The final amendment report was submitted to the Director approximately one month later. (166) [s. 104. (3)]

Issued on this 11 day of May 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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LYNDA BROWN (111) - (A2)

Inspection No. / No de l'inspection : 2017_360111_0001 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 035430-16 (A2)

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

Report Date(s) / Date(s) du Rapport : May 11, 2017;(A2)

Licensee / Titulaire de permis : CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8

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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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Andrea Loft

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To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall complete the following:

1. Equip all doors located in each home area that lead to stairwells to which residents have access with an audible door alarm that is separate from the resident-staff communication and response system. The alarm shall be capable of being cancelled only at the point of activation.
2. Equip the front main foyer doors located in the older section of the building which lead to an unsecured outdoor area and to which residents have access, with an audible door alarm that is separate from the resident-staff communication and response system. The alarm shall be capable of being cancelled only at the point of activation.
3. Connect two stairwell doors to which residents have access located in the basement to the resident-staff communication and response system.
4. Equip all interior doors that lead to the retirement home and to which residents have access, with an audible door alarm that is separate from the resident-staff communication and response system. The alarm shall be capable of being cancelled only at the point of activation.
5. Connect all interior doors that lead to the retirement home and to which residents have access, to the resident-staff communication and response system.
6. Connect the main foyer doors located in the older section of the building to the resident-staff communication and response system.

Grounds / Motifs :

1. The licensee did not ensure that the following rules were complied with:

Doors that residents had access to and led to stairways and unsecured outdoor areas of the home were not equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and were not connected to the resident-staff communication and response system.

A) Eight doors leading to stairwells to which residents had access were checked. These doors were located in the main foyer (near the elevator), two in the Birch home area, one in the Linden home area, two in the Cedar home area and three in the Aspen home areas and did not have an audible alarm located at the door. When each door was tested, it was confirmed to be connected to the resident-staff communication and response system (at various enunciator panels) and an audible sound within the corridors was heard. However, each door did not have a separate

audible alarm at the door that would sound until a staff member cancelled the alarm at the door.

B) The front main entrance door to the long term care home, which led to an unsecured outdoor area was not equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and was not connected to the resident-staff communication and response system. When the door was tested, the Linden area nursing station was identified by staff as the closest station to the door. The audio visual enunciator located at the nurse's station included a visual light labelled "front door", but it did not light up when the door was left open for more than one minute. The exit door leading from the Aspen home area to an unsecured outdoor area did not have an audible alarm at the door and it could not be confirmed if the door was connected to the Aspen home area audio visual enunciator.

C) Two stairwell doors accessible to residents in the basement (near the recreation room and chapel) were not equipped with an audible door alarm or connected to the audio visual enunciator at the Maple nurse's station. Management staff could not confirm if the doors were connected to any of the other enunciator panels within the home. Maintenance staff could not provide any drawings or a reference confirming which stairwell door and which door leading to the outside was connected to which enunciator panel and were not aware that the doors were not connected to the resident-staff communication and response system (via enunciator panels).

D) Two sets of glass doors leading to the retirement home area located in the basement (near the auditorium and a stairwell) and one set of doors located on the main floor leading to the retirement home area were not connected to any audio visual enunciator at any of the nurse's stations and were therefore not connected to the resident-staff communication and response system. The doors were not equipped with an audible alarm. Doors that separate a retirement home from a long term care home area considered the equivalent of doors leading to an unsecured outdoor area.
(120)

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

Jul 17, 2017

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order / Ordre :

The licensee shall:
-put a monitoring process in place during each meal, including who will be responsible to ensure that all residents requiring assistance and/or encouragement with meals are provided the encouragement and assistance they need in order to they receive the nutritional intake as required.
-ensure that all food service workers and any staff assisting residents, know the residents diet and texture and any special needs and preferences.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a process to ensure that food service workers and other staff assisting residents were aware of the resident's diets, special needs and preferences.

Observation of the lunch service in the main dining room (Linden servery) on a specified date by Inspector #111 indicated the dietary aide (DA #109) did not refer to the resident diet list while providing resident meals. PSW # 114 requested the meal choice and texture but did not identify the resident names when requesting food plates from the DA. PSW # 113 was requesting meal choice by resident names only and the DA did not refer to the resident diet list to ensure they received the correct diet and texture. The DA began asking the nursing staff to refer to the resident diet list after the inspector asked the DA why the resident diet list was not referred to.

Interview with the Nutritional Care Manager (NCM), by Inspector #111 indicated it is the DA responsibility to refer to the diet list prior to serving meal choices for each resident, not the nursing staff. [s. 73. (1) 5.] (111)

(A1)
2. The licensee has failed to ensure that there was a process to ensure that food service workers and other staff assisting residents were aware of the resident's diets, special needs and preferences.

Observation of the lunch service in the main dining room (Linden servery) on a specified date by Inspector #111 indicated the dietary aide (DA #109) did not refer to the resident diet list while providing resident meals. PSW # 114 requested the meal choice and texture but did not identify the resident names when requesting food plates from the DA. PSW # 113 was requesting meal choice by resident names only and the DA did not refer to the resident diet list to ensure they received the correct diet and texture. The DA began asking the nursing staff to refer to the resident diet list after the inspector asked the DA why the resident diet list was not referred to.

Interview with the Nutritional Care Manager (NCM), by Inspector #111 indicated it is the DA responsibility to refer to the diet list prior to serving meal choices for each resident, not the nursing staff. [s. 73. (1) 5.] (623)

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

Mar 31, 2017(A1)

Order # /
Ordre no : 003

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 that the licensee??s Abuse and Neglect policy is complied with and a monitoring process is developed and implemented to protect residents in incidents of alleged, suspected or witnessed abuse and/or neglect.

The monitoring process shall include, but is not limited to:
a) a process whereby residents exhibiting sexually inappropriate responsive behaviours are identified, triggers to the behaviours are identified, and for each behaviour identified,
strategies are implemented to assist staff in managing the responsive behaviours;
b) a process whereby the Director of Care and/or delegate is reviewing all communication from the front line staff at least daily to determine the presence of suspected, alleged or witnessed incidents of resident abuse and/or neglect;
c) a process whereby an effective information-sharing protocol amongst all members of the multidisciplinary health care team, the residents, their families is established to ensure supervisory and management staff always have current, reliable and comprehensive information about suspected, alleged or witnessed incidents of resident abuse and/or neglect;
d) a process whereby, when there are reasonable grounds to suspect that abuse and/or neglect has occurred, the licensee and/or delegate immediately conducts a thorough investigation, ensuring that all legislative requirements have been fulfilled (both internal and external reporting requirements), especially as it relates to the assessment of the residents involved and the implementation of interventions to meet their needs for support and protection;
e) revision of the licensee's policy relating to 'Zero Tolerance of Abuse and Neglect', specifically, actions to be taken when allegations, suspicions or witnessed incidents of staff to resident neglect occur, including assessments of residents, and including actions to be taken by the home that include support to be provided to the residents, investigating and reporting

requirements, and documentation related same.
f) a process to assess the knowledge and skills of all staff in relation to the implementation of the licensee??s Abuse and Neglect policy, in order to effectively address deficiencies through targeted, focused and individualized interventions; and
f) a formal linkage to the home??s quality improvement program, to ensure that all aspects of the development and implementation of the required monitoring process are documented, reviewed and analyzed on an ongoing basis to determine the need for further corrective actions.

Grounds / Motifs :

1. 1. The licensee failed to ensure that residents were protected from staff to resident verbal or physical abuse and/or neglect by staff and other residents, and failed to ensure vulnerable, cognitively impaired, residents were protected from alleged, suspected or witnessed sexual abuse by another resident, pursuant to s.19 of the LTCHA.

Under O.Reg. 79/10, s.2(1) For the purposes of the definition of "abuse" in subsection 2(1) of the Act, “sexual abuse” means,(a) subject to subsection (3), (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Under O.Reg. 79/10, s.2(1), For the purposes of the definition of "abuse" in subsection 2(1) of the Act,
-"emotional abuse" means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour, or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a residents.
-"physical abuse" means, subject to subsection (2)(a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Under O.Reg. 79/10, s. 5, For the purposes of the definition of "abuse" in subsection 2(1) of the Act, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

1. Related to log #001738-17:

Critical Incident Report (CIR) was submitted to the Director on a specified date related to an alleged staff to resident verbal and physical abuse that was reported to Inspector #626 in stage one of the RQI. Inspector #626 reported the alleged incidents to the Administrator on the same day. Resident #010 reported the previous evening, two staff were rough when providing care and resulted in pain. The resident also indicated that PSW #139 and PSW #149 also made inappropriate comments towards the resident regarding personal care. The resident indicated the incidents were reported to RPN #120 the following morning (the same day the Inspector was notified). The RPN did not report the allegation to the RN, DOC or Administrator until the following day during the investigation.

Interview with RPN #120 by Inspector #626 confirmed that the resident did report the alleged inappropriate comments made by the PSW #139 and #140 but was not informed of any incidents of physical abuse or rough handling. The RPN was uncertain of the date the RPN was informed. The RPN indicated was not informed of any incidents of physical abuse or rough handling. RPN #120 indicated that the resident had requested the RPN not to report the allegation but should have reported it immediately.

In an interview with the Administrator by Inspector #626 indicated that RPN #120 did not immediately report the allegations of staff to resident verbal abuse until the home's investigation the day after the allegation was received. The Administrator indicated that it is the expectation that staff report incidents of abuse immediately to their RN supervisor.

The licensee failed to ensure the written policy that promotes zero tolerance of abuse and neglect of residents was complied with as RPN #120 failed to immediately report an incident of staff to resident rough handling and emotional abuse as issued under WN #14 under s.20(1)(a)(626).

2. Related to log #020568-16:

A critical incident report (CIR) was submitted on a specified date for an alleged staff to resident neglect. The CIR indicated at a specified time, resident #015 was observed yelling and making threatening remarks towards resident #053. The

incident was witnessed by PSW #151 and PSW #152, who did not intervene. RPN #132 then witnessed the incident and intervened. RPN #132 forwarded a complaint regarding the incident the same day indicating the staff failed to intervene. The CIR was not amended to provide the outcome of the licensee's investigation into the allegation.

An off-site enquiry was made to the Administrator on a specified date requesting the outcome of the licensee's investigation but the information was not provided. An inspection was then initiated a week later and the Administrator was asked for the investigation and outcome of the investigation. One staff interview was provided to the inspector at that time but no outcome of the investigation. Review of the health record of resident #053 indicated there was no documented evidence of the incident or to indicate the resident was assessed as per the home's Zero Tolerance of Abuse policy. Further interview with Administrator confirmed she should be interviewing all staff who may have been involved in the incident, documenting the outcome of the investigation and the CIR should have been updated with the outcome.

Interview with Social Worker (SW) indicated she is responsible for maintaining the home's complaint log and enters all verbal and written complaints that are received once the investigations are completed. The SW was not aware of any verbal complaint received by the home on the specified date regarding allegations of staff to resident neglect towards resident #053. The SW indicated the acting DOC or Administrator are responsible for providing all verbal or written complaints to the SW.

-Review of the home's investigation and interview of staff indicated the home's Zero Tolerance of Abuse policy was not followed as: there was no documented evidence of the incident or to indicate resident #053 was assessed or offered support related to verbal abuse received by resident #015. The two PSW staff also failed to intervene as issued under WN #14 under LTCHA, 2007, s.20(1)(a).
- The licensee failed to ensure that a documented record was kept in the home that included: the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response, and; any response made by the complainant the verbal complaint made by the RPN regarding neglect was not documented in homes complaint log as issued under WN #22 under O.reg. 79/10, s.101(2)
-The CIR was not updated within 21 days of the incident, with the outcome of the

investigation as the CIR was not updated as of the time of the inspection, six months later, as issued under WN #23 under O.Reg. 79/10, s.104(3).

3. Related to log # 002431-17:

Critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect that occurred over a two day period at specified times. The CIR indicated resident #061 (who is cognitively well) had reported staff to resident neglect towards resident #057 by PSW #129. Resident #061 reported additional staff were also aware of the incident. The CIR did not indicate which staff were involved in the allegation.

Interview with Administrator and acting DOC by Inspector #111, indicated PSW #129 was involved in the alleged neglect and resident #061 (who reported the allegation), were both interviewed two days later. The Administrator indicated the home determined the PSW #129 had provided care related to toileting to resident #057 on both dates. The Administrator indicated that PSW #129 could not provide a specified task due to lack of supplies available. Interview of the Administrator the following day indicated she forgot that she had also interviewed three other PSW's on the same day the allegation was made but did not document the interviews. The Administrator concluded the investigation and indicated the allegations were unfounded.

Review of the current written care plan for resident #057 indicated the resident is at risk for skin breakdown related to incontinence and interventions included: resident will not call for assistance with toileting, staff are to check and change the resident every 2-3 hours and as needed.

Review of the licensee's investigation, interview of staff, and review of the resident #057 health record indicated a complaint was received by resident #061 on a specified date regarding an allegation of staff to resident neglect that occurred towards resident #057 by PSW #129. The home's investigation indicated that PSW #123, #139, #145, #165 were involved or present in the allegation and their names were not provided in the CIR. The outcome of the investigation was unfounded despite the licensee's investigation indicating PSW #129 did not provide care to resident #057 as indicated in the plan related to toileting. PSW #123 reported assisting PSW #129 with toileting of resident #057 once per shift on the specified dates and indicated resident #057 required more frequently toileting. Interview with PSW #139 by Inspector #111 indicated resident #057 required toileting 3-4 times per

shift. Resident #057 was not toileted as indicated in the plan.

-There was no documented evidence of the incident or to indicate resident #057 was assessed, as per the home's Zero Tolerance of Abuse and Neglect policy, as issued under WN #14 under LTCHA, 2007, s.20(1)(a).
-There was no documented evidence the investigation was completed immediately and no actions were taken related to the resident not being toileted as per the resident's plan of care or the lack of supplies available to complete a specified task as issued under WN #15 under LTCHA, 2007, s.23 (1)(a).
-The care set out in the plan of care was not provided to the resident as specified in the plan related to toileting as issued under WN #12 under LTCHA, 2007, s.6(7).
-The CIR was not amended to indicate which staff were involved with the allegation despite staff awareness two days after the allegation was made, as issued under WN #23 under O.reg.79/10, s.104(1)2.

4. Related to log # 027318-16:

The Ministry of Health after hours was called on a specified date to report an incident of injury of unknown cause to resident #045. A CIR was not submitted at that time. A CIR was submitted four months later as a result of an off-site enquiry. The CIR indicated at a specified time, RPN #117 noted an injury to a specified area to resident #045 and suspected rough handling by a staff or resident. The CIR indicated the outcome was pending the investigation. The CIR indicated the SDM was not notified of the incident.

Interview with the Administrator by Inspector #111 requesting the outcome of the investigation indicated the investigation was not yet completed (five months later). The Administrator confirmed the SDM was not notified of the incident.

Review of resident #045 progress notes indicated on a specified date and time, an RPN noted an injury to a specified area and suspected possible rough handling by a staff or resident due to location of injury. The RPN interviewed the PSW who was assigned to resident #045 and confirmed the injury was noted at start of shift but did not report to the RPN. The home did not complete the investigation to determine if the investigation was founded or unfounded. The home also failed to submit the CIR within 10 days of the incident. The licensee's Zero Tolerance of Abuse and Neglect policy was not complied with as an injury of unknown cause was not immediately reported by the PSW and there was no documented evidence to indicate that

appropriate actions were taken.

-Review of the home's investigation and interview of staff indicated the home's Zero Tolerance of Abuse and Neglect policy was not followed related to failure to immediately report the injury suspected physical abuse as issued under WN #14 under LTCHA, 2007, s.20(1)(a).
-The licensee failed to ensure the resident's SDM and any other person specified by the resident, were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being as issued under WN #21 under O.Reg. 79/10, s.97(1)(a).
-The licensee failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director as issued under WN #23 under O.Reg. 79/10, s.104(2).

5. Related to log #002520-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse that occurred on the same day at a specified time. The CIR indicated program staff (PS #171) had reported resident #046 had reported being rough handled earlier in the day during care and had been occurring over the last two weeks to RN Manager #118 (the same day).

Review of the care plan for resident #046 indicated the resident had specified sleeping preferences.
Review of the licensee's investigation indicated on the specified date and time, resident #046 reported the PSW "is rough" and was upset and weepy while reporting the incident to PS #171. The SDM of resident #046 was present when the allegation was reported to PS #171 and confirmed incidents had been occurring over a two week period. RN Manager #118 did not report the allegation until the following day, when the police were notified. RN Manager #118 indicated the alleged PSW involved in the incident was PSW #172 and was interviewed two days later.

Interview with the Administrator by Inspector #111, confirmed that no other staff were interviewed regarding the allegation, the investigation was completed and determined to be inconclusive. The Administrator indicated as a result of the

discussion with the Inspector, that other staff would be interviewed before the home determined the outcome.

-The investigation was not completed immediately as the investigation did not start until two days after the allegation was made of staff to resident rough handling and no other actions were taken to prevent a recurrence despite the resident not receiving care as per the resident's written plan of care, as issued under WN #15 under LTCHA, 2007, s.23(1)(a).
-The care set out in the plan of care was not provided to the resident as specified in the plan related to sleep preferences as issued under WN #12 under LTCHA, 2007, s.6(7).

6. Related to log # 033626-16 & # 034927-16:

A critical incident report (CIR) was received on a specified date for an allegation of staff to resident neglect. The CIR indicated the SDM of resident #049 brought forth complaints to RN Manager #118 regarding improper care and neglect to resident #049 by PSW #144. The CIR indicated the SDM also submitted a written complaint eight days later regarding the incidents that occurred and the resident "was upset" and requested not to have the same PSW providing care for the resident.

Review of the written complaint from the SDM of resident #049 indicated on a specified date and time, the resident reported PSW #144 had provided improper care and neglected the resident throughout the shift. The SDM indicated the allegations were reported to the acting DOC the same day they occurred as the resident was in discomfort. The SDM indicated PSW #173 and RPN #137 were also aware and or present when the improper care and neglect occurred.

Interview with acting DOC and RN Manager #118 by Inspector #111, confirmed the home was aware of a verbal complaint alleging staff to resident neglect on the day the incidents occurred (followed by a written complaint seven days later) and the investigation was not initiated until four days later. The acting DOC indicated the SDM was notified the outcome of the investigation was inconclusive.

Review of resident #046 progress notes had no documented evidence of the allegation or indication of an assessment of resident #046 related to the discomfort. The licensee's investigation indicated the resident (who was capable) was never interviewed regarding the incident and no indication any emotional support was

provided.

Interview with Social Worker (SW) indicated she is responsible for maintaining the home's complaint log and enters all verbal written complaints that are received once the investigations are completed. The SW was not aware of any verbal or written complaint received by the home on specified dates regarding allegations of neglect towards resident #049.The SW indicated the acting DOC or Administrator are responsible for providing all verbal complaints (via client feedback forms) or written complaints to the SW.

Review of the home's complaint log for the two specified months did not have any indication of a verbal or written complaint received by the SDM of resident #049 related to neglect.

Review of the licensee's investigation and interview of staff indicated the home was aware of allegations of improper care and neglect towards resident #049 "who was upset" and in discomfort, on the day the incidents occurred, and the Director and police were not notified until the following day. The licensee's investigation and interview of staff by Inspector #111 indicated RPN #137, PSW # 173, PSW #174 and PSW #175 were present and or aware of the allegations and were not identified on the CIR. The home informed the family that the outcome of the investigation was "inconclusive" and PSW #144 was allowed to continue to provide care to resident #049.

-Review of the licensee's investigation and interview of staff indicated the licensee's policy was not followed related to the investigation process and there was no documented evidence the resident was assessed related to allegations of staff to resident neglect as issued under WN #14 under LTCHA, 2007, s.20(1)(a).
-There was no indication the investigation was completed immediately and there was no indication that appropriate actions were taken as a result of the licensee's investigation, when the allegations were confirmed, as issued under WN #15 under LTCHA, 2007, s.23(1)(a).
-The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: 1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm as issued under WN #16 under LTCHA, 2007, s.24 (1).
-The licensee failed to ensure that the report to the Director included the following

description of all of the individuals involved in the incident: (ii) names of any staff members or other persons who were present at or discovered the incident as issued under WN #23 under O.Reg. 79/10, s.104 (1)2.
-The licensee failed to ensure that a documented record was kept in the home of a verbal and written complaints received in November and December 2016 that included: the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response, and; any response made by the complainant as issued under WN #22 under O.reg. 79/10, s.101(2)

7. Related to log # 023595-16:

A critical incident report (CIR) was submitted to the Director on a specified date for an allegation of resident to resident sexual abuse. The CIR indicated on a specified date and time, resident #043 and resident #044 were found demonstrating sexually inappropriate behaviour in resident #044 room and were not separated by staff for a specified period of time. Both residents were then supervised by staff for a specified period of time when resident #043 was redirected out of resident #044 room. The CIR indicated both residents are cognitively impaired and "neither resident is able to provide consent for sexual behaviour". The CIR indicated “Internal Investigation initiated". The CIR was not amended to indicate the outcome of the home's investigation. The CIR indicated 1:1 staffing was put in place and referral to BSO as a result.

Observation of resident #043 on a specified date by Inspector #111 indicated the resident was cognitively impaired and was independently mobile with use of a mobility aide. Resident #044 was no longer in the home.

Review of the progress notes for resident #043 and #044 related to sexually inappropriate responsive behaviours and/or sexual abuse indicated:the behaviours occurred over a three month period but in both residents' progress notes, the co-residents were not identified. There were seven documented incidents where resident #043 & #044 were observed demonstrating sexually inappropriate responsive behaviours. There were 2 incidents where suspected resident to resident sexual abuse and two incidents of suspected resident to resident sexual abuse that were not documented to indicate when they occurred and with whom.

The triggers and strategies for both resident #043 & #044 did not indicate which female/male resident(s) they were having inappropriate sexual behaviours towards; Resident #043 had demonstrated inappropriate sexual responsive behaviours towards more than one co-resident and this trigger was not identified; The plan of care did not clearly indicate what the "sexually inappropriate" behaviour included despite the progress notes for both residents clearly indicating what these behaviours and triggers included. The incident of resident #043 inappropriately touching another unidentified co-resident (as reported by an RN during an interview) was also not identified to indicate when it occurred and towards whom. The strategies to manage the sexually inappropriate responsive behaviours was also not clear as there was no indication how staff would monitor each of the two residents or what "increased observation" included. The observation period was unclear and sometimes resident #043 was placed on 1:1 and other times on every 15 minute observations. The sexually inappropriate responsive behaviours was accepted by some staff as a 'relationship' and therefore did not intervene. The relocation of resident #044 to another unit was used as a strategy but was not considered until after the seventh incident and despite permission provided by the SDM after the fifth incident. There was no indication of a referral to psychogeriatric services despite the ongoing behaviours of sexually inappropriate behaviours and BSO discontinued resident #043 from the program despite continuing to display sexually inappropriate responsive behaviours.

Interview with Administrator by Inspector #111 regarding the incident indicated an investigation was completed but she was unable to locate the investigation. The Administrator indicated she was unaware the CIR was never amended to indicate the outcome of the home' investigation.

- There was no indication the investigation was completed immediately and appropriate actions were taken as the investigation had not yet been completed or concluded five months later, as issued under WN #15 under LTCHA, 2007, s.23(1) (a).
-The licensee failed to ensure that for resident #043 & #044 demonstrating sexually inappropriate responsive behaviours, the behavioural triggers for the resident were identified, where possible, strategies were developed and implemented to respond to these behaviours, where possible, and actions were taken to respond to the needs of the resident, including assessment, reassessments and interventions, and that the resident's responses to the interventions are documented as issued under WN #17

under O.Reg. 79/10, s.53(4)(a)(b).

8. In addition, the licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected and did not contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate, as issued under WN #20 under LTCHA, s.96(a)(b).

A Compliance Order was warranted as the scope and severity was demonstrated by the following:
1. A Compliance Order (CO #001), was issued during a Critical Incident Inspection (#2015_360111_0014), on June 3, 2015, under LTCHA, 2007, s.19(1), which included a written notification (WN) specific to LTCHA, 2007, s. 6(7), 20(1), 23(1)(a), 24 (1), 97(1) & 98 with a compliance date of August 15, 2015. A second CO (# 001), was issued during the Resident Quality Inspection(RQI) (#2015_365194_0028), on November 16, 2015, under LTCHA, 2007, s19 (1) which included a WN specific to LTCHA, 2007, s.20(1), 23(2) and s.24(1) with a compliance date of April 30, 2016. The order was complied with on August 5, 2016. In addition, LTCHA, 2007, S.23 (2) was issued during a Complaint Inspection (#2016_327570_0010), on April 25, 2016 which included a voluntary plan of correction (VPC) and O.Reg.79/10, s.104(2) with a WN at that time. A WN was issued during the RQI (#2016_327570_0014) for LTCHA, 2007, s.23(2). A WN was issued during RQI (#2016_327570_0014) for O.Reg.79/10, s.104(1)2. A WN was issued during a Complaint Inspection (#2016_327570_0022) specific to LTCHA, 2007, s. 6(7).
2. There was actual harm to residents related to physical, emotional, and sexual abuse towards multiple residents (both cognitively well and cognitively impaired resident). There was also a pattern of inaction related to allegations and complaints of staff to resident neglect as demonstrated by the above logs. [s. 19. (1)] (111)

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

Jun 30, 2017(A2)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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

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

Issued on this 11 day of May 2017 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN - (A2)

Service Area Office /
Bureau régional de services : Ottawa

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
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Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 25, 2017	2017_643111_0012	001827-17, 003415-17, 005854-17, 007837-17, 008910-17, 008920-17, 015450-17, 016758-17, 016955-17, 017305-17, 017729-17, 018265-17, 019541-17, 019828-17	Critical Incident System

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

LYNDA BROWN (111), CRISTINA MONTOYA (461), PATRICIA MATA (571), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 10, 11, 14-18, 21-

25, 28-31, September 1, 5-8 and off-site October 4, 2017.

The following critical incident report was reviewed during this inspection: Log # 018265-17 related to a fire in the home.

In addition, the following critical incidents reports were completed concurrently during this inspection but were not related to the non-compliance in this report:
Log # 017305-17, 017729-17, 008910-17 related to alleged staff to resident neglect;
Log # 016955-17, 005854-17, 003415-17, 001827-17, 019828-17 & 007837-17 related to alleged staff to resident abuse;
Log # 008920-17 & 015397-17 related to alleged resident to resident abuse;
Log #019541-17 related to unexpected death;
Log # 015450-17 & 016758-17 related to fall resulting in significant change in condition.
Additional non-compliance for Log # 017305-17, # 016955-17, # 005854-17 # 008920-17 & # 015397-17 was identified under the Complaint Inspection # 2017_643111_0013.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Director of Quality Nursing, Nursing Administrative Assistant, Program Director, Nutrition Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Supervisor(FSS), Resident Care Area Managers (RCAM), Therapy Nurse (ET Nurse), Electrical Safety Authority (ESA), College Of Trades, Public Health Unit Inspectors, Behavioural Supports Ontario (BSO) staff, Social Worker, Recreation Aide, Operations Manager, Corporate Consultant, Former Acting DOC, Physiotherapist Assistant (PTA), Physiotherapist (PT), Occupational Therapist (OT), Administrative Assistant, Environmental Services Manager (ESM), Environmental Services Supervisor (ESS), contractors, and residents.

During the course of the inspection, the inspector(s) also reviewed health records, investigations, staff training records, complaint logs, observed meal services and reviewed the following policies: Zero Tolerance of Abuse and Neglect, Skin and Wound Care Program, Falls Prevention, Complaints, Staffing Plans, Contractors and Nutrition and Hydration.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 :

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is:
a) in compliance with and is implemented in accordance with all applicable requirements under the Act, and b) complied with.

Under O.Reg. 79/10, s.86(3) The licensee shall ensure there are written policies and procedures to monitor and supervise persons who provide occasional maintenance or repair services to the home pursuant to the agreement referred to in subsection (2).

Review of the Licensee's policy "Contractors-Duties and Responsibilities Policy" (revised January 25, 2017) indicated under Maintenance Personnel:
-close off areas in which the work is being carried out.
- ensure that electric cables, hoses, etc., used by the Contractors are used in such a manner so as not to cause tripping hazards or unsafe conditions.
- monitor the compliance with Health & Safety legislation and safe work practices periodically as the project progresses.

On a specified date and time, Inspector #111 observed a set of double glass doors in the basement that lead to the retirement home. Beside the doors was a ladder left in use, above the ladder the ceiling tile was opened with wires exposed, and alarm pads and parts were left sitting in a box on the floor. There was no contractor or maintenance personnel present and the area was not closed off. The Environmental Services Supervisor (ESS) was notified at that time and indicated the area was being used by a contractor who must have just left to get additional tools from their truck.

Related to log # 018265-17:

A Critical Incident Report (CIR) was received by the Director on a specified date for a fire that occurred in the home. As a result of the fire, there were contractors in the home completing repairs to overhead light fixtures.

On a specified date, a complaint was received by Inspector #111 from a Public Health Inspector, regarding observed contractors in the home completing electrical work in resident rooms in an unsafe manner, on a specified date and time.

Interview with ESS by Inspector #111, indicated all contractors that enter the home are

required to sign in the contractor log book located at the receiving dock in the basement. The ESS was unable to indicate who was responsible for monitoring and supervising the contractors who entered the home to ensure the contractors followed safe work practices. The ESS indicated no awareness of whether there were any contractors currently in the home and had not checked the contractor log book. The ESS indicated the Environmental Services Manager (ESM) would be able to indicate who was responsible for monitoring contractors in the home. The ESM was not currently in the home.

Review of the contractor log book on a specified date and time (by Inspector #111 and ESS) indicated there were a specified number of contractors signed in the home during a specified time period. The log did not indicate which type of contractor was in the home, where they were performing the work, or what time they left. The ESS was able to identify two of the contracted workers in the home as 'electrical workers' but was unaware of where the contractors were completing the work and had not monitored the contractors today.

Observation of a specified unit, on a specified date and time by Inspector #111, identified four of the contractors that were performing electrical work. Three of the contractors were completing lighting repairs on the ceiling light fixtures just inside the entrance to three resident rooms. In each of the rooms, the residents were present and the area was not closed off for resident safety. In one identified resident room, a family member was also present in the resident room and was attempting to exit the room, around the workers ladder that was blocking the exit. There was also a power tool sitting on the floor in the hallway with the charger plugged into the receptacle and the area was not closed off. Residents were observed wheeling their wheelchairs around the power tool in the hallway. Interview with one of the contractors indicated the power tool should not have been left in the hall unattended and immediately removed the power tool and charger.

In addition, the following day, interview with resident #038 by Inspector #111, indicated that he/she noted on the previous day, during a specified time, the door alarm and lock at the front door was not working, for a specified time period. The resident stated he/she reported it and observed staff exiting the home, so they were aware the door was not alarmed or locked. The resident also indicated he/she had prevented two residents from exiting the home. Inspector #571 noted the front doors were not locked and alarmed at 1500 hours and reported the incident to the DOC.

Interview with the ESS on a specified date, by Inspector #111 indicated the door lock and

alarm was unintentionally deactivated when a contractor was working on a door alarm in the basement and had disconnected the front door alarm/lock. The ESS was unaware what time the contractor entered the home or left. The ESS indicated the contractor was called back to reconnect the lock/alarm at the front door. Review of the contractor log book indicated the contractor entered the home on a specified date and time but did not indicate what time they left. There was no indication that contractor had also returned to the home later that same day.

Interview with ESM on a specified date by Inspector #111, confirmed awareness of Public Health Inspectors being in the home the previous week and had expressed some concerns regarding contractors doing work (lighting repairs) unsafely. The ESM indicated the obligation from ESM (and ESS in his absence) is to be aware of any contractors in the home and to monitor the contractors to ensure they are following safe work practices and as per the Licensee's Contractor policy re: maintenance personnel.

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 licensee's policy related to contractors-duties and responsibilities is complied with by the ESM and the ESS, to be implemented voluntarily.

Issued on this 30th day of October, 2017

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

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 25, 2017	2017_643111_0014	007051-17, 007053-17	Follow up

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 10, 11, 14-18, 21-25, 28-31, September 1, 5-8 and off-site October 4, 2017.

Additional information was gathered under the Critical Incident inspections (inspection #2017_643111_0013).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Director of Quality Nursing, Nursing Administrative Assistant, Program Director, Nutrition Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Supervisor(FSS), Resident Care Area Managers (RCAM), Therapy Nurse (ET Nurse), Electrical Safety Authority (ESA), College Of Trades, Public Health Unit Inspectors, Behavioural Supports Ontario (BSO staff), Social Worker, Recreation Aide, Operations Manager, Corporate Consultant, Former Acting DOC, Physiotherapist Assistant (PTA), Physiotherapist (PT), Occupational Therapist (OT), Administrative Assistant, Environmental Services Manager (ESM),

During the course of the inspection, the inspectors also reviewed health records, investigations, staff training records, complaint logs, observed meal services and reviewed the following policies: Zero Tolerance of Abuse and neglect, Skin and Wound care Program, Falls Prevention, Complaints, Staffing Plans, Contractors and Nutrition and Hydration.Environmental Services Supervisor (ESS), contractors, and residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were not issued.
- **0 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #003	2017_360111_0001	111
O.Reg 79/10 s. 9. (1)	CO #001	2017_360111_0001	111

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.

Issued on this 25th day of October, 2017

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

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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347 rue Preston bureau 420
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Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 8, 2017	2017_643111_0013	002637-17, 003590-17, 004285-17, 005741-17, 006958-17, 008774-17, 009287-17, 009329-17, 013929-17, 014938-17, 014980-17, 015397-17, 016984-17, 017491-17, 018204-17, 019022-17, 020744-17, 021111-17	Complaint

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

LYNDA BROWN (111), CRISTINA MONTOYA (461), PATRICIA MATA (571), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 10, 11, 14-18, 21-25, 28-31, September 1, 5-8 and off-site October 4, 2017.

The following complaint inspections were completed concurrently during this inspection:
Log # 003590-17, 014938-17 & 013929-17 related to insufficient staffing;
Log # 009287-17, 008774-17 & 017491-17 related to alleged staff to resident neglect;

Log # 014980-17& 016984-17 related skin and wound care and resident charges;
Log #018204-17, 005741-17 & 009329-17 related to alleged resident to resident abuse;
Log#002637-17 related to responsive behaviours;
Log #006958-17 related to medication incidents;
Log #004285-17 related to end of life care and pain management;
Log # 019022-17, 021111-17 & 020744-17related to falls and complaints.

In addition, the following critical incident reports were completed concurrently during this inspection but non-compliance was identified in this report as they were directly related to the complaints:
Log # 017305-17 related to alleged staff to resident neglect;
Log # 016955-17 related to alleged staff to resident abuse;
Log # 008920-17 & 015397-17 related to alleged resident to resident abuse;

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Director of Quality Nursing, Nursing Administrative Assistant, Program Director, Nutrition Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Supervisor(FSS), Resident Care Area Managers (RCAM), Therapy Nurse (ET Nurse), Electrical Safety Authority (ESA), College Of Trades, Public Health Unit Inspectors, Behavioural Supports Ontario (BSO) staff, Social Worker, Recreation Aide, Operations Manager, Corporate Consultant, Former Acting DOC, Physiotherapist Assistant (PTA), Physiotherapist (PT), Occupational Therapist (OT), Administrative Assistant, Environmental Services Manager (ESM), Environmental Services Supervisor (ESS), contractors, and residents.

During the course of the inspection, the inspector(s) also reviewed health records, investigations, staff training records, complaint logs, observed meal services and reviewed the following policies: Zero Tolerance of Abuse and Neglect, Pain

Management, Skin and Wound care Program, Falls Prevention, Complaints, Staffing Plans, Contractors and Nutrition and Hydration.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Resident Charges
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

The licensee failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

A. There were multiple complaints received through the Ministry of Health and Long-Term Care Action Line related to personal support staffing shortages impacting resident's care.

Interview with DOC by Inspector #111, indicated that the home is divided into 6 units (Aspen, Linden, Maple, Cedar, Birch and Pine). The DOC indicated Pine unit is the largest unit and has 49 residents.

Review of the Personal Support Workers (PSW) staffing schedule for a specified month in 2017 for a specified unit indicated there were a specified number of days when the unit was working short- staffed.

Interview with Nursing Administrative Assistant (Staff #120) by Inspector #111, indicated the home usually has the most short-staffing (with PSWs not at full compliment) on two specified units and usually occurs on specified shifts. Staff #120 indicated they are from sick call-ins or no-shows and usually occur over a four day period, resulting in the units working short-staffed (not working at full PSW compliment).

Interview with the Administrator by Inspector #111, indicated she identified the home was experiencing issues with PSW staffing related to a number of sick calls, no shows and vacancies. The Administrator indicated the home is working at recruiting staff to fill vacancies and disciplinary actions related to absenteeism. The Administrator indicated they also posted two memo's for staff on two specified months in 2017 related to concerns with staff no-shows and attendance concerns (111).

B. Related to log #017491-17 & # 008774-17:

Review of the Resident Council meeting minutes for 2017 by Inspector #461 indicated in a specified month, the residents expressed concerns related to inconsistency in PSW staffing, residents not receiving the same PSW on a regular basis and happening for the past six months. There was also a concern that the breakfast for a specified unit in the dining room was always late, PSWs were still getting residents ready for the day and not able to be in the dining room to provide assistance with feeding/serving, was consistently short-staffed within the nursing department resulting in inconsistency with staff providing care to residents. Review of the Resident's Council meeting minutes for four specified

months, indicated the residents were unhappy with changes in the dining room times and wanted the breakfast time changed back to 0815 hours. Residents indicated the service was too rushed and there was not enough time between breakfast and lunch.

On a specified date, Inspector #461 observed the breakfast meal service (scheduled to start at 0845 and to finish by 0930 hours) in all dining rooms. The large main dining room was divided by the various home areas: Linden, Birch, Maple, and Pine. Inspector #461 observed at 0845 hours, residents were being served fluids only and the actual meal service did not commence until 0900 hours. There were residents also noted to be missing from the dining room. The breakfast meal service was still occurring at 0945 hours.

Interview with RPN #127 and PSW #141 on a specified date by Inspector #461, indicated that a specified unit had been short-staffed for the past five days. Both staff indicated on this specific date they were also short-staffed (not at full PSWs compliment) which lead to residents arriving late for breakfast. PSW #141 indicated at 0900hours, there were six residents still waiting to be taken to the dining room for breakfast.

On a specified date, during separate interviews with the Nutrition Manager #114 and Program Director #126, by Inspector #461, both indicated the breakfast start time was changed from 0815 to 0845 hours on a specified date without input from the Resident's Council. The Nutrition Manager indicated the start of breakfast time was changed because PSWs did not have enough time to bring all the residents to the dining room for breakfast.

On a specified date, Inspector #461 observed the main dining room for breakfast and noted the following: at 0845 hours, staff were noted still bringing residents into the dining room for breakfast; at 0900 hours, a PSW reported that they were still waiting for 2 residents to arrive; at 0905 hours, approximately 30 residents were sitting at their tables with just their drinks and had not yet received the hot cereal or any other breakfast items. The residents were not offered hot cereal until approximately 0920 hours; at 0910 hours, table #7 had four residents seated, including resident #022. The resident asked the Inspector for hot cereal (as there was no staff to assist) and indicated the resident had been waiting for approximately 15 minutes. At the same table, only 1 out 4 residents had received their hot cereal; at 0920 hours, the Inspector noted one resident was waiting to be brought to the dining room for breakfast. The resident was brought to the dining room at 0925 hours. There were still several residents in main dining room (specifically on Birch and Pine unit) that were still having breakfast after 0930 hours.

Interview with the Operations Manager (former acting Administrator) by Inspector #571, indicated that breakfast time was changed from 0815 to 0845 hours because when breakfast was served at 0815 hours, three quarters of the residents were not in the dining room to begin the breakfast meal. The former interim Administrator indicated with change in meal time, the breakfast meal was now completed between 0915 and 0930 hours. The former interim Administrator confirmed that an evaluation of the time change had not been completed to determine if the meal time change had been effective.

On a specified date, Inspector #461 observed the main dining room for the breakfast meal, and noted the following where residents from a specified unit were located: at 0850 hours, the residents had not yet received their fluids and there were no PSWs available to assist with meal service; at 0905 hours, residents were still arriving to the dining room and at 0910 hours, PSW #168 from the Birch unit arrived to the dining room and starting serving the residents on this unit; at 0925 hours, all four PSWs from the Birch unit were now present in the dining room. At 0930 hours, resident #012 was provided the main course of breakfast. Resident #012 stated to the Inspector the meal service at breakfast "was late almost every day". At 0938 hours, resident #025 arrived to the dining room, PSW #124 indicated that resident usually comes to the dining room independently but needs reminders, because they were short a PSW staff, the resident was forgotten in their room. Resident #025 received the breakfast meal at 0942 hours. At 1000 hours, resident #026 was served the breakfast meal, despite being seated in the dining room since 0850 hours. At 1005 hours, PSW #168 had prepared food trays for residents on isolation (resident #027, #029, and #030). The PSW has also prepared a fourth tray for resident #032. The PSW reported to the Inspector that resident #032 normally came to the dining room but the PSW did not have time to get the resident up for breakfast. PSW #168 also indicated that being short-staffed greatly affected the care provided to residents in the morning. The breakfast meal service on this date did not conclude until 1030 hours. Inspector #461 noted the morning snack was to be served at 1030 hours and lunch provided at 1200 hours. The home was not providing adequate time between the breakfast and the lunch meal to promote healthy appetite and ensure adequate nutritional intake for residents.

During an interview with the Administrator by Inspector #461, indicated awareness of the residents getting to the dining room late for breakfast and therefore not leaving the dining room until after 0930 hours. The Administrator also indicated the breakfast time change was yet to be evaluated (461).

C. Related to log # 003590-17 & # 002637-17:

Interview with resident #017 by Inspector #111 indicated the regular PSW was away for a specified period of time and ever since then, the resident has had a new PSW every day. The resident also indicated the resident was supposed to have a shower and hair washed in the morning approximately a week ago, but the staff were too late getting to the resident due to PSW short-staffing. The resident indicated the shower was refused because of an appointment at that time and was upset.

Interview with PSW #147 by Inspector #111, indicated resident #017 has a shower two days per week. The PSW indicated the resident prefers to have the shower before breakfast but the staff cannot always provide the shower at that time. The PSW indicated the shower sometimes has to be later in the morning due to PSW short-staffing (PSW not working at full compliment) and the resident will then refuse (111).

D. Related to log # 017305-17:

A critical Incident Report (CIR) was received by the Director on a specified date for an alleged staff to resident neglect. The CIR indicated resident #014 had reported a verbal complaint the resident was not toileted as requested two days prior for a period of two hours.

Review of the resident #014 health record, review of the licensee's investigation and interview of staff (PSW #134 & #135) by Inspector #111, indicated on a specified date and time, resident #014 had rang the call bell and requested assistance with toileting. Resident #014 required two staff assistance with a mechanical lift. PSW #134 indicated he/she would get assistance and the mechanical lift and return but did not return until approximately two hours later with PSW #135. The resident was incontinent, was upset and crying as a result. PSW #134 indicated that they were working short-staffed (PSW not working at full compliment) that evening and had to wait for PSW #135 to be able to assist with toileting (111).

E. Related to log # 014938-17:

An anonymous complaint was received by the Director regarding the home always working short-staffed (PSWs not at full compliment), especially in the evenings, and on the unit with 49 residents.

Interview with PSW #140 on a specified unit by Inspector #111, on a specified date indicated the unit was working short-staffed today (PSW not at full compliment) and has worked short-staffed for the last five days in a row. The PSW reported to Inspector #461 that the staff were late getting residents to the dining room for breakfast (not until after 0900 hours) as a result. In an interview with PSW #140 on a specified date by Inspector #111 indicated the same specified unit has been short-staffed on a specified shift every day for last two weeks.

Interview with PSW #123 & #125 and RPN #121 on a different specified unit by Inspector #111 on a specified date, indicated they frequently work short- staffed, usually 3-4 times per week. The PSW's indicated they were working short-staffed again today. The PSW's indicated they were a half hour late getting the residents down to the dining room for lunch as a result. The PSW's indicated one PSW had to remain on the floor to assist with toileting during the meals so they only had 3 PSW's to assist with feeding 41 residents.

Interview with the Administrator by Inspector #111 indicated she identified the home was experiencing issues with PSW staffing related to a number of sick calls, no shows and vacancies. The Administrator indicated the home is working at recruiting staff to fill vacancies and disciplinary actions related to absenteeism. The Administrator indicated they also posted two memo's for staff in two specified months related to concerns with staff no-shows and attendance concerns.

The severity of this non-compliance indicated that there was potential for harm/risk as the organized personal support staffing was not meeting the needs of the residents, and the scope was a demonstrated pattern as there was two out of six resident units where the PSWs were noted not working at full compliment. This impacted the resident care by the following: resident #014 was not toileted as requested for a period of two hours, resulted in the resident being upset; several residents on two specified units were not receiving their breakfast meals in the dining room and/or within the designated meals times (despite the meal time being changed to a later time). Not providing adequate time between the breakfast, morning snack, and the lunch meal does not promote healthy appetite and ensure adequate nutritional intake for those residents; and resident #017 who requested showers to be provided before breakfast to accommodate an appointment, was occasionally not receiving a shower on those days when PSWs were work short-staffed (111).

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

The licensee has failed to ensure that residents are not charged for goods and services that they are required to provide using funding.

Related to Log #014980-17:

A review of the Family Council meeting minutes for a specified date, by Inspector #571 indicated that foot care was an unfunded service and in future, a charge of twenty five dollars would be charged to those residents and the service would be provided every eight weeks. The minutes indicated the service was optional and another provider could be chosen. Review of a memo, with a specified date, indicated that effective June 13, 2017, residents would be charged for foot care services as historically, the home provided the unfunded service at no charge but were no longer able to continue.

In an interview with Extendicare Operations Manager (former acting Administrator) by Inspector #571, clarified that the memo and Family Council meeting minutes were referring to advanced foot care only. The Operations Manager indicated that the licensee was previously providing advanced foot care at no cost to the residents and since advanced foot care was an unfunded service, the licensee decided to hire an outside advanced foot care nurse to provide advanced foot care services to residents. The Operations Manager indicated the total advanced foot care charge was thirty five dollars which included: thirty dollar charge for the foot care nurse and five dollar charge that was used to pay a PSW (employee of the home) to porter the residents to a central location in the home for the foot care service.

In an interview by Inspector #571 with the Administrator, indicated that the advanced foot care was provided in each resident room rather than in a central location. The Administrator indicated, the advanced foot care service by an outside provider was a new process and the licensee was still working on the process.

The licensee provided a list to Inspector #571 that indicated 84 residents had been charged and paid for the 35 dollar advanced foot care, which included the five dollar portering charge, since June 13, 2017.

The licensee receives funding through the nursing and personal care envelope from the Ministry of Health and Long Term Care. Such funding would include portering of residents to all areas within the long term care home. Therefore, the five dollar charge for portering is prohibited (571).

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

The licensee has failed to ensure there was an interdisciplinary falls prevention and management program fully implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

Related to log # 020744-17:

Review of progress notes for resident #037 indicated in 2017 the resident sustained twelve falls over an eight month period. After the sixth fall, and concerns expressed from the family of the resident, two devices were implemented to reduce potential injury. The resident was transferred to hospital after the 11th fall.

Interview with Physiotherapist (PT) #186 by Inspector #111 indicated he/she usually receives a referral for any residents who have fallen (either on paper or electronically) and both the PT and PTA's review Point Click Care (PCC) daily for any residents who have fallen. The PT indicated when a referral is received, they would complete an

assessment and provide strategies for falls prevention. The PT indicated resident #037 was previously a moderate risk for falls but then changed to a high risk for falls after returning from hospital (post fall). The PT was aware resident #037 was having frequent falls. The PT indicated he/she had not attended any Falls Prevention Program meetings in 2017 and indicated the Falls Prevention Lead was RCAM #188.

Interview with Physiotherapy Assistant (PTA) #183 by Inspector #111 indicated the SDM of resident #037 inquired about a tilt wheelchair to prevent further falls and the PTA notified the Occupational Therapist (OT) to complete a seating assessment. The PTA indicated awareness the resident was sent to the hospital post fall. The PTA indicated awareness of other falls prior to hospitalization. The PTA indicated upon return from hospital, the resident was confined to a wheelchair.

Interview with RCAM #188 by Inspector #111 indicated he/she was the lead for falls prevention program but indicated has not been able to have any meetings for the last six months. Indicated the last documented meeting was approximately seven months ago. The RCAM indicated resident #037 was a high risk for falls and was aware the resident had several falls in the last couple of months. The RCAM indicated he/she reviewed the previous month falls that were occurring in the home and noted that resident #037 had been having several falls, but had not been able to review plan of care. The RCAM also indicated awareness of concerns with family regarding an injury prevention device that was not effective and the families request to reassess the device, but not sure of exact date this concern was brought forward or actions taken.

Resident #037 sustained 11 falls since the Falls Prevention Team last met. There was no indication that the Falls Prevention Program was implemented with the aim to reduce the incidence of falls and the risk of injury until after the family expressed concerns.(111) [s. 48. (1) 1.]

2. The licensee failed to ensure that the skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions, was fully implemented in the home.

A review of the licensee's Skin and Wound Program: Prevention of Skin Breakdown (RC-23-01-01) and Wound Care Management policy (RC-23-01-02), last updated February 2017 indicated the program gives directions including the following:
- RC-23-01-01: to designate a Wound Care Lead to coordinate the program and work with the interdisciplinary team to ensure program implementation and effectiveness;

conduct wound rounds and quality improvement reviews regularly. Appendix 1 directs the nurse to inform Wound Care Lead, Physician/Nurse Practitioner (NP) of any new and/or worsening skin breakdown and as need; complete surveillance as required.
-RC-23-01-02: the Nurse or Wound Care Lead to: promptly assess all residents exhibiting altered skin integrity on initial discovery; use a Bates Jensen Wound Assessment Tool for pressure ulcers/venous stasis or ulcer of any type; use an Impaired Skin Integrity Assessment Tool for all other skin impairments (i.e., skin tears, rashes, reddened areas, bruises); monitor resident skin condition with each dressing change, re-assess at minimum weekly; re-evaluation and documentation of treatment with creams and other medicated preparations should occur at minimum weekly; initiate one Bates-Jenson Wound Assessment for each open area/wound; complete the Bates-Jensen Assessment if condition worsening or not improving as expected, but at a minimum every seven days; photograph pressure ulcers and complex wounds as needed to track healing and assess treatment effectiveness;

Related to Log # 016984-17:

Resident #005 was admitted to the home with diagnoses that included alteration in tissue perfusion, history of skin breakdown and wounds to specified areas. The resident was hospitalized on two separate occasions related to wounds since admission. A review of the clinical health record over a seven month period, from the time of admission, indicated the following:
-the following month after admission, the resident's wounds were assessed by an Enterostomal Therapy (ET) Nurse and new treatments were ordered for wounds to specified areas.
-the following month, the dressings and the wounds, on specified areas, were noted to have a foul smell. A week later, moderate, foul smelling drainage was noted from specified wounds. A week later, a specified wound had a change in the amount and type of discharge. A week later, the resident was assessed by the ET Nurse and recommended a new treatment, and suggested antibiotics for specified wounds due to infection.
-the following month, resident was reassessed by the ET Nurse, the resident was sent to hospital due to skin related changes to specified areas and treated with antibiotics. The resident returned from hospital a month later and continued the antibiotic therapy. A week later, another wound to a specified area was noted to be deteriorating. A week later, dressing changes to specified wounds indicated excessive bleeding and the Physician was notified. The Physician discontinued specified treatments.
-two days later, a specified wound was noted to further deteriorate and was reported to

the Resident Care Area Manager (RCAM). A referral was made to the Wound Care Lead.
-three days later, a Weekly Impaired Skin Integrity Assessment was completed and indicated the wound over one specified area had deteriorated further, and identified four other areas with altered skin integrity.
-three days later, a Bates-Jensen Assessment was completed and indicated the wound to a specified area had deteriorated further.
-a week later, the Weekly Impaired Skin Integrity Assessment indicated the wound to a specified area was larger and further deteriorated.
-a week later, a Bates-Jensen Assessment indicated the wound to a specified area was larger and the four other wounds to specified areas were also getting larger. There was also two additional wounds noted.
-a week later, all wounds were noted to have large amount of foul smelling drainage and the resident was crying out in pain. The Physician was contacted and the resident was transferred to hospital for assessment.

A review of the clinical health records for resident #005 indicated over a seven month period in 2017, the Bates-Jenson skin assessment was completed as follows:
-on a specified date, two assessments were completed, one for multiple wounds to a specified area and one for multiple wounds to another specified area. The Inspector was unable to determine what the measurements were for which wounds and descriptions of the wounds due to multiple wounds listed.
-the following month, two assessments were completed, one for multiple wounds to a specified area and one for multiple wounds to another specified area. The Inspector was unable to determine what the measurements were for which wounds and descriptions of the wounds due to multiple wounds listed. o
-two months later, one incomplete assessment was completed for a specified area which was lacking wound measurements.
-six days later, one assessment was completed for a specified area with multiple skin breakdown to specified areas.
-the following month, one assessment was completed for a specified area with specified measurements.
-the following month, one assessment was completed for five different specified areas with specified measurements. The specified areas measured larger than the previous month with additional areas.
-the following month, one assessment was completed for multiple wounds to two specified areas.
-six days later, one assessment was completed for two wounds to a specified area and

In an interview with Inspector #571, RPN #117 indicated that resident #005 had returned from the hospital on a specified date with a wound to a specified area and described the wound. RPN # 117 indicated no awareness of requirement to complete weekly Bates-Jensen assessments for specified types of wounds. RPN #117 indicated the RCAM/Wound Care Lead (#130) was notified of the wound.

In an interview with Inspector #571, RCAM/Wound Care Lead (#130) indicated that resident #005 was admitted to the home with multiple wounds so he/she arranged to have an Enterostomal Therapy (ET) Nurse come in to assess resident #005's wounds monthly. The ET Nurse did not assess the resident in one specified month as the home was in outbreak. RCAM #130 indicated that he/she had just become aware that the Bates-Jensen wound assessments had to be completed for all wounds, not just pressure ulcers. RCAM #130 indicated that the Skin and Wound Program policy was new and that he/she is still learning about the Program. In addition, he/she indicated the nurses were to track all wounds on the wound tracking form but that the forms were not always completed. The RCAM indicated when a resident had a new, challenging or worsening wound, staff were to submit an electronic referral to the wound care lead but he/she was not always able follow up on the referrals right away. The RCAM indicated wounds were not photographed in the home.

There was no documented evidence to indicate the Bates-Jensen weekly skin assessment (the clinically appropriate assessment instrument) was completed 17 times during a five month period for resident #005's multiple wounds. The Bates-Jensen assessments were not completed weekly for each of the wounds that resident #005 had, it was not clear when the resident started to display signs and symptoms of a specified tissue alteration diagnosis and this diagnosis was not discovered until the NP completed a monthly assessment of the resident and sent to the hospital. Also, it was unclear what the status of resident #005's wounds were from week to the next week and exactly where the wounds were located, as the licensee was not ensuring that registered nursing staff were using a Bates-Jensen tool weekly for each wound.

There was no documented evidence that photographs were taken of any of resident #005's wounds. There was no documented evidence to indicate that the physician or Nurse Practitioner was notified when resident #005's wounds displayed signs and symptoms of infection on a specified date (wounds were noted to be foul smelling), until the ET Nurse completed the monthly wound assessment approximately three weeks later and recommended antibiotics. There was no documented evidence to indicate that the

physician or Nurse Practitioner was notified when resident #005's wounds were increasing in size (deteriorating). The licensee failed to ensure that their interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was implemented.

Since resident #005's admission to the home, resident #005 developed and/or had multiple, worsening wounds and included infection to her bilateral arms and legs that resulted in two hospitalizations. In addition, a wound over the left Achilles tendon deteriorated from 4 cm long by 3 cm wide on June 1, 2017, to 12cm by 7.5 cm with an exposed tendon on July 9, 2017. The licensee failed to ensure that correct documentation, assessment or follow-up was conducted as per their Skin and Wound Program. A Compliance Order was issued as a result under O. Reg. 79/10, s. 48 (1) 2., due to the severity and negative outcome towards resident #052. [s. 48. (1) 2.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the interdisciplinary falls prevention and management program is fully implemented in the home, with the aim to reduce the incidence of falls and the risk of injury., to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident related to food allergies.

Related to log # 008774-17:

An anonymous complaint was received by the Director on a specified date, indicating that resident #003 had an allergy to a specified food item and was being offered the specified food item at meal times.

Record review for resident #003 indicated an allergy to the specified food item was listed

on both the written plan of care and listed under allergies on the electronic health record (under the profile tab). Review of the diet list used as reference for staff to serve meals, indicated the specified food item was listed as a dislike and not as an allergy. Review of the Registered Dietitian (RD)'s most current assessment completed, indicated the resident disliked the specified food item and did not identify the specified food item as an allergy.

During an interview with PSW #118, PSW #133 and RPN #116, by Inspector #461, PSW #118 indicated resident #003 was allergic to the specified food item; PSW #133 did not know that resident had an allergy or dislike for the specified food item; RPN #116 indicated that the resident had no allergies to the specified food item.

During an interview with RD by Inspector #461, indicated resident #003 had no allergy to the specified food item and was more of a dislike, according to the resident's POA. The RD confirmed that the instructions to the staff around resident #003's food allergies and dislikes were not clear.

The written plan of care for resident #003, did not set out clear directions for staff and others who provide direct care to the resident related to food allergies. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #021 as specified in the plan, related to toileting.

A. Related to log #017305-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect incident towards resident #014. The CIR indicated two days before at a specified time, the resident was not toileted for a specified period of time.

Review of the written plan of care for resident #014 (in place at time of incident) under toileting/continence indicated: the resident was incontinent, wears an incontinence product, requires two staff assistance with mechanical lift and the resident to be reminded to use call bell when assistance is required.

Review of the licensee's investigation, review of resident #014's health record and interview of staff indicated: on a specified date and time, the resident had rang for assistance with toileting. PSW #134 responded to the call bell and informed the resident

she/he would have to get the mechanical lift and a co-worker (PSW #135) to assist with toileting. The PSW indicated PSW #135 was unable to return to assist the resident for a specified period of time. The PSW returned to the resident approximately two hours later and the resident was upset as a result. PSW #134 indicated no other staff were asked to provide assistance with toileting despite two other PSW's working on the unit and indicated they were working short-staffed that evening as well (111).

B. Related to Log # 019022-17:

A review of the written care plan for resident #021 (at time of incident) indicated under toileting, an intervention (initiated prior to the incident) directing staff not to leave the resident unattended on the toilet. An intervention of an alarming device was also to be used to alert staff when the resident was going to the bathroom.

Review of the progress notes for resident #021 indicated that on a specified date and time, resident #021 was found sitting on the bathroom floor, with an injury to a specified area. The PSW reported the resident had been left on the toilet unattended by a staff member.

In an interview with Inspector #571, RPN #192 indicated resident #021 had history of multiple falls. The RPN indicated on a specified date, when resident #021 sustained the fall, the resident was left unattended on the toilet by a PSW.

On a specified date and time, Inspector #571 observed resident #021 sitting in a mobility aide in his/her room. The resident then proceeded to enter the bathroom and attempted to self-transfer to the toilet. The alarming device did not activate and the Inspector noted the alarming device was turned off.

In an interview with RPN #179 by Inspector #571, indicated that she/he has to remind staff all the time to not turn off the alarming device.

The licensee failed to ensure that the care set out in the plan of care related to toileting was provided to the resident as specified in the plan, specifically, the alarming device and supervision with toileting.

A Compliance Order was warranted as the Licensee has had ongoing non-compliance with ensuring resident's plan of care were provided to residents, as specified in their plan, related to LTCHA, 2007, s.6(7). The Licensee was issued a Written Notification (WN) for

s.6(7) under Compliance Order (CO)#002 for LTCHA, 2007, s.19 (1) on June 3, 2015 during a critical incident inspection (#2015_360111_0014) and was returned to compliance on November 30, 2015. LTCHA, 2007, s.6(7) was issued as a WN on June 8, 2015 during a critical incident inspection (#2015_293554_0009). LTCHA, 2007, s.6(7) was issued as a (CO) on July 5, 2016 during the RQI inspection (#2016_327570_0014) and was returned to compliance on January 9, 2017. The Licensee was issued a (WN) for LTCHA, 2007, s.6(7) on October 4, 2016 during a complaint inspection (#2016_327570_0022). The Licensee was also issued a (WN) for s.6(7) under Compliance Order (CO)#003 for LTCHA, 2007, s.19 (1) on January 16, 2017 during a RQI inspection (#2017_360111_0001) with a compliance date of June 30, 2017. [s. 6. (7)]

3. The licensee failed to ensure when the resident was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care related to pain management.

Related to logs #006958-17 and #008774-17:

On a specified date, during an interview with the complainant by Inspector #461, indicated that resident #003 had been on the same pain medication for over six months and had requested the resident's pain medications be reviewed as the resident continued to complain of pain to a specified area.

Review of resident #003 current written plan of care related to pain management indicated that resident had chronic pain due to a specified diagnosis and interventions included: registered staff to report to physician if medications are ineffective in managing resident's pain.

Review of resident #003 progress notes indicated on a specified date in 2016, the resident's family member reported to RN #019 that the resident's pain to a specified area was worsening. RN #109 assessed the resident' and identified the pain was 6 out 10 on the Bates Jensen Faces Pain Scale. The resident described the pain as sharp and the only time the resident did not experience pain was when sleeping. The RN spoke with the physician who provided a referral to the BSO team, the pharmacist to review resident's medication and a referral to a pain specialist. RN #109 indicated the pain consultation was cancelled as resident was in the hospital, and that consultation would be rescheduled at a later date. There was no indication the consultation was rescheduled.

During an interview with RPN #116 by Inspector #461, indicated resident #003 never had a consultation with the pain specialist or the BSO team.
During interview with Physiotherapy Assistant (PA) #128 by Inspector #461, indicated resident #003 still complained of pain to a specified area every time the PA completed exercises to the specified area. PA #128 indicated that resident's pain level had not changed in the last six months.

Review of the electronic Medication Administration Record (eMAR) for resident #003 for a three month period indicated the resident was ordered and received two oral and one transdermal pain medications.The resident received one of the oral analgesics seven times over the three month period when the resident's pain level ranged from 4-5 out of 10 on the pain scale. The most recent pain assessment completed on a specified date and time indicated the resident presented a pain level of 6 out 10, but no analgesic was administered.

During an interview with RN #109 with Inspector #461, indicated she/he was concerned about the resident's pain to a specified area during a specified month in 2016 and asked the physician for a pain consultation. The RN stated the consultation and the BSO "fell through the cracks and never took place". The RN indicated the resident continues to experience chronic pain to the specified area and requires a pain consultation.

Resident #003 was reassessed, but the plan of care was not revised when care set out in the plan had not been effective, and different approaches considered, related to pain management (461).

4. The licensee failed to ensure when the resident was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care related to falls prevention.

Related to log # 020744-17:

A verbal complaint was received by the Licensee from the family of resident #037 on a specified date, regarding the resident sustaining numerous falls in a specified month in 2017. The complainant indicated the resident was provided with fall protective equipment as result of the complaint. The family expressed concern to the home regarding an improper fit of one of the fall protective equipment but no actions were taken.

Review of the progress notes for resident #037 indicated the resident sustained 12 falls in 2017. In two specified months, the resident sustained most of the falls. After the second fall, specified interventions were implemented. After the sixth fall, the SDM was very upset and fall protective devices were suggested and implemented. Staff were reminded to ensure fall protective equipment was in place after the eighth and ninth fall. After the eleventh fall, when the resident was transferred to hospital, staff indicated the resident did not like to use the fall protective devices, would remove them and refused to use the assistive device.

Review of the written plan of care for resident #037 (revised after the fifth fall) indicated the resident was a high risk for falls. Interventions included: has a mobility aide but does not use, seek out resident's whereabouts to ensure the resident has not fallen, alarming device to be in place, fall protective devices to be in place due to recent increase in falls, monitor daily for change in mental status, identify root cause of falls, falling star, bed rails removed, and Hi/Lo bed with bed kept in lowest position.

Telephone interview with Occupational Therapist (OT) by Inspector #111, indicated he/she was aware of resident #037 having frequent falls and root causes. The OT indicated a referral was received on a specified date for a seating assessment, completed the seating assessment, recommended the use of a specified mobility aide and the mobility aide was ordered as the family agreed. The OT indicated no awareness related to concerns with a specified fall protective device.

Interview with PSW #196 by Inspector #111 indicated resident #037 was a high risk for falls and used a mobility aide with an alarming device. The PSW indicated the resident no longer used the specified protective device as the resident would remove the device.

Interview with RPN # 197 indicated the resident was a high risk for falls and a specified protective device was discontinued recently at the family's request.

Interview with RCAM #188 by Inspector #111 indicated she/he was the lead for falls prevention program. The RCAM indicated resident #037 was a high risk for falls and indicated awareness the resident had sustained several falls in two specified months.The RCAM indicated awareness of concerns from family regarding a specified fall protective device that was improperly fitted and the RCAM had requested a proper fitting protective device from OT but not sure of exact date.

The plan of care was not revised, and different approaches considered when the interventions used where demonstrated to be ineffective, as the resident continued to fall. The resident sustained 8 falls before additional interventions were considered (protective devices) and only as a result of the family expressing concerns. The protective device was also noted to have an improper fit and intervention of a proper fitting device was discussed but never implemented. An additional intervention (mobility aide) was also not considered until the family again expressed concerns regarding the ongoing falls (and after the resident sustained four more falls). [s. 6. (11) (b)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that their written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Review of the Licensee's policy "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" (updated April 2017):
-(RC-02-01-01), page 3/8, promptly investigate resident to resident altercations, complaints and unexplained bruising or injuries to determine root cause and put in place measures to prevent recurrence.
-(RC-02-01-02), anyone who witnesses or suspects abuse or neglect of a resident by

another resident, staff or other person must report the incident. Staff must complete an internal incident report and notify their supervisor. The Nurse would then call the Manager on-call immediately upon suspecting or becoming aware of abuse or neglect of a resident.Management will promptly and objectively report all incidents to external regulatory authorities.On page 2/5, the Administrator has the authority to place an employee on Leave of Absence with pay, pending the results of the investigation. On page 3/5, all staff are to ensure the safety of and provide support to the abuse victim(s) through completion of full assessments, a determination of residents needs and a documentation plan to meet those needs. Other specialized supports to resident/families involved in the alleged incident (e.g. social work counselling). In case of physical and/or sexual abuse, accurate detailed descriptions of injuries/condition are documented in the resident chart.
- (RC-02-01-03), page 3/5, the Administrator or designate, immediately advise the employee that they are being removed from the work schedule, with pay, pending the investigation, the investigating manager/supervisor will: fully investigate the incidents in keeping with the step as outlined in the investigation toolkit; Under Appendix 2, page 2/8, collect employee statements; page 4/8, prior to the start of your interviews, create a list of all witnesses who have direct or indirect knowledge of the incidents, take note to add them to you interview list; page 5/8, have the employee sign off on the notes. This places the onus on the note taker to write clear, legible and detailed notes. Write the date and time of the interview as well as who was present in the room during the interview; on Page 8/8, collect all documents from the investigation and organize it for filing in an appropriate, secure and confidential location.

A. Related to log #017305-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect incident towards resident #014. The CIR indicated on a specified date and time, resident #014 reported to the Social Worker the resident had requested to be toileted and was not toileted for approximately four hours by PSW #135. The CIR was amended eight days later and indicated the investigation revealed that the incident actually occurred three days before the CIR was submitted, involved PSW #134 and the resident was not toileted for two hours. The CIR indicated the resident was upset and crying as a result of the incident. The CIR indicated the allegation was unfounded.

Review of the progress notes of resident #014 had no documented evidence of the incident that occurred on the specified date and time until three days later when a progress note was completed by the Social Worker (SW). The SW indicated they were

notified of a verbal complaint by resident #014, the resident was visibly upset and crying. The SW indicated the resident also reported the staff were not treating the resident with respect and dignity and requested to be relocated. The SW indicated the DOC, Administrator and RCAM were notified of resident's concerns.

Review of the staff schedule indicated PSW #134 continued to provide resident care on four specified dates prior to the initiation of the investigation.

Review of the licensee's investigation and interview of staff indicated resident #014 reported the allegation to the Social Worker two days after the incident occurred and the resident requested to be relocated. The resident informed the Social Worker the allegation was also reported to the night RN (RN #167) the same day the incident occurred. The Social Worker emailed the allegation to the DOC and did not call the on-call manager/supervisor as per the licensee's policy. The investigation notes were completed by the DOC and were not signed by the staff. The notes indicated PSW #134 and #135 were interviewed eight days after the incident was reported and continuing to provide care to residents on specified dates. PSW #134 reported they were working short staffed when the incident occurred and had to wait for approximately two hours for PSW #135 to provide assistance with toileting and the resident was upset. PSW #134 indicated the incident was reported to the charge nurse the same time the incident occurred. The licensee's investigation indicated no other staff were interviewed regarding the allegation (other PSW's, RPN and the RN that worked when the incident occurred). The DOC indicated the SDM was notified of the outcome of the investigation eight days later (when the investigation was started) and determined the allegation was unfounded. The DOC confirmed there was no investigation into the other allegations reported to the Social Worker by the resident and request to be relocated.

Interview with DOC and Administrator by Inspector #111 indicated the expectation of all staff, including managers is to immediately assess the resident, provide emotional support as needed, registered staff to document the incident and all managers/supervisors to utilize the investigation toolkit for completing all investigations. They both indicated this policy was not complied with related to this allegation of staff to resident improper care, despite determining the allegation was unfounded (111).

B.Related to Log # 016955-17:

A critical incident report (CIR) was submitted on a specified date for an improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm that

occurred seven days prior at a specified time. The CIR indicated PSW #101 provided care to resident #015, put the resident in bed and noticed an injury to a specified area on the resident but did not report the injury. PSW #145 and RPN #149 observed the injury to a specified area. RPN #149 questioned PSW #101 regarding the injury to determine cause and the PSW reported the injury was noted when after providing care but unknown cause. RN #150 and the SDM were notified.

Interview with PSW #101 indicated the PSW was relieved of duty the same day the injury was noted to resident #015. The PSW indicated the DOC questioned the PSW the following day. The PSW indicated she/he then continued to provide care to resident #015 on three separate dates until the DOC changed the work assignment which would not include resident #015.

During an interview with the DOC, she indicated that when conducted interviews she took notes in a note book. The DOC further indicated, she should have used the Complaint Investigation Form when conducting and documenting the interviews as part of the investigation. A later interview with the DOC, she indicated that the investigation into the incident was determined to be not founded. The DOC indicated no awareness that PSW #101 continued to provide care to resident #015 that her instruction to RPN #149 were to change the PSW's work assignment. The DOC indicated the PSW involved with the incident should not have continued to provide care to resident #015. The DOC indicated that she became aware of the incident the next day and the incident should have been immediately reported to the Director when RN #150 became aware of the incident.(570)

Review of the licensee's investigation notes provided to Inspector #570 included written notes only. The written notes had no date and time identified to indicate when the interview took place and there were no employee signature on the notes.

During an interview with the Administrator by Inspector #570, she indicated that it is the expectation that managers should use the designated investigation forms when conducting investigations related to complaints and abuse allegations.

The licensee has failed to comply with the written policy that promotes zero tolerance of abuse and neglect of residents specific to conducting investigations (#570).

C. Related to Log #005854-17:

A critical incident report (CIR) was received by the Director on a specified date for an

alleged staff to resident abuse. As per CIR notes, a family member of a co-resident reported a PSW was providing improper care to resident #004. The CIR indicated the allegation was determined to be unfounded. The CIR was completed by the Extendicare Long-Term Care consultant.

Review of the licensee's investigation contained a Client Feedback Log that indicated the investigation was completed on a specified date and concluded that the allegation of abuse was unfounded. There was no other documents from the investigation (i.e. interviews/statements).

Interview with the Extendicare Long-Term Care consultant by Inspector #570 indicated that she could not locate the investigation notes and that all records pertaining to the investigation should have been documented and kept in a secure place (570).

D. Related to Log # 018204-17:

A critical incident report (CIR) was submitted to the Director for an alleged resident to resident abuse incident that occurred on a specified date and time. The CIR indicated resident #012 was abusive towards resident #013.

Review of the licensee's investigation notes provided to Inspector #570 included a one page written note. The written note had no date and no time identified to indicate when the interview took place. Further, there was no employee signature on the note.

During an interview with the DOC by Inspector #570, she indicated that when conducted interviews she took notes in a note book. The DOC further indicated, she should have used the Complaint Investigation Form when conducting and documenting the interviews as part of the investigation.
During an interview with the Administrator by Inspector #570, she indicated that it is the expectation that managers should use the designated investigation forms when conducting investigations related to complaints and abuse allegations.

The licensee has failed to comply with the written policy that promotes zero tolerance of abuse and neglect of residents specific to conducting investigations.(#570).

A Compliance order was warranted as the Licensee has had ongoing non-compliance with ensuring the policy to promote zero tolerance of abuse and neglect of residents, which includes investigations are to be completed immediately and appropriate actions

are taken, and allegations or suspicions are immediately reported to the Director. In addition, the licensee's failure to immediately report/investigate and take appropriate actions, increases the severity of harm to the residents. The licensee was issued LTCHA, 2007, s.20(1) on the following dates: a Written Notification (WN) under Compliance Order (CO) for LTCHA, 2007, s.19 (1) on June 3, 2015 during a critical incident inspection (#2015_360111_0014) and was returned to compliance on January 15, 2016; a (WN) under Compliance Order (CO) for LTCHA, 2007, s.19 (1) on November 16, 2015 during the RQI inspection (#2015_365194_0028) and was complied with on August 5, 2016; a (WN) under the (CO) for LTCHA, 2007, s.19 (1) on January 16, 2017 during the RQI inspection (#2016_360111_0001). [s. 20. (1)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

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 :

The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:(i) Abuse of a resident by anyone and to ensure the results of the abuse or neglect investigation were reported to the Director.

Related to log # 009329-17 & #008920-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged resident to resident abuse. The CIR indicated resident #009 reported that resident #010 had been inappropriate towards the resident on a specified date. Resident #009 had also submitted a written complaint to the DOC two days after the incident occurred and indicated there had been ongoing incidents over the last four months. The CIR was completed by the Extendicare Consultant (acting DOC in place at time of incidents). The CIR was updated nine days later and indicated a response letter was provided to the resident but did not indicate the outcome of the licensee's investigation.

Review of the progress notes of resident #009 & resident #010, and the licensee's investigation indicated RPN #142 was notified of the allegation of resident to resident

abuse by resident #010 towards resident #009 on a specified date and time by resident #009. The following day, resident #009 reported the allegation a second time to a recreation aide. Resident #009 then submitted a written complaint to the acting DOC regarding the incident and previous abuse towards resident #009 by resident #010.

Review of the progress notes for resident #009 and #010 over a five month period indicated there were five additional incidents of alleged abuse by resident #010 toward resident #009.

Interview with resident #009 by Inspector #111 indicated she/he immediately reported the allegation of resident to resident abuse to RPN #142 after the incident occurred. The resident indicated no action was being taken, the resident was frustrated with resident #010 ongoing abuse, so two days later, the resident wrote a complaint letter to the home and the Director.

Interview with RPN #142 by Inspector #111 indicated on a specified date and time, resident #009 approached the RPN and reported that resident #010 had been abusive towards the resident and was upset. The RPN indicated she/he did not report the allegation because the incident was unwitnessed. The RPN indicated the incident was documented.

Interview with DOC and Administrator by Inspector #111 indicated the expectation of all staff, including managers is to immediately assess the resident, provide emotional support as needed, registered staff to document the incident and all managers/supervisors to utilize the investigation toolkit for completing all investigations. They both indicated this policy was not complied with related to this allegation of staff to resident improper care, despite determining the allegation was unfounded (111). Interview with the acting DOC (who was in place at time of allegations) by Inspector #111 indicated she became aware of the allegation of resident to resident abuse between resident #009 and resident #010 when she received the written compliant (two days after the incident was reported). The acting DOC indicated she submitted a written response to resident #009 which indicated an investigation was completed into each allegation and measures were put in place to address the concerns. The acting DOC indicated she initiated the investigation when she received the written complaint but could not provide the investigation into any of the alleged abuse incidents. The acting DOC was only able to provide an interview with RPN #142. The acting DOC indicated no other investigation was completed despite indicating such in the response letter to resident #009. In addition, the allegations of resident to resident abuse that occurred on four other

separate dates were not investigated.

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

Related to log #017305-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect. The CIR indicated on a specified date, resident #014 reported the allegation of staff to resident neglect by PSW #135 to the Social Worker. The CIR was amended eight days later, indicated as a result of the investigation, the incident actually occurred two days earlier than initial date provided and involved a different PSW (PSW #134). The CIR also indicated as a result of the investigation, the length of time of the neglect was shorter than initially indicated. The CIR indicated the resident was upset as a result of the incident. The CIR indicated the investigation concluded the allegation was unfounded.

Interview with resident #014 by Inspector #111 indicated the resident was still upset regarding the incident and felt the home took no actions to prevent a recurrence. The resident indicated the night RN was notified of the allegation the same day the incident occurred.

Review of the licensee's investigation and interview of staff indicated resident #014 reported the allegation to the Social Worker two days after the incident occurred and the resident requested to be relocated. The resident informed the Social Worker the allegation was also reported to the night RN (RN #167) the same day the incident occurred. The Social Worker emailed the allegation to the DOC and did not call the on-call manager/supervisor as per the licensee's policy. The investigation notes were completed by the DOC and were not signed by the staff. The notes indicated PSW #134 and #135 were interviewed eight days after the incident was reported and continuing to provide care to residents on specified dates. PSW #134 reported they were working short staffed when the incident occurred and had to wait for approximately two hours for PSW #135 to provide assistance with toileting and the resident was upset. PSW #134 indicated the incident was reported to the charge nurse the same time the incident occurred. The licensee's investigation indicated no other staff were interviewed regarding the allegation (other PSW's, RPN and the RN that worked when the incident

occurred). The DOC indicated the SDM was notified of the outcome of the investigation eight days later (when the investigation was started) and determined the allegation was unfounded. The DOC confirmed there was no investigation into the other allegations reported to the Social Worker by the resident and request to be relocated.

Interview with the DOC by Inspector #111 indicated she received an email regarding the allegation from the Social Worker the following day (three days after the incident). The DOC indicated that was when she began the investigation into the allegation. The DOC indicated the resident was interviewed, informed the DOC the allegation was reported to the RPN the day after the incident occurred. The DOC indicated she could not recall which RPN the resident reported the incident to and she did not speak to either the RPN or RN #167. The DOC indicated she did not investigate the other allegations of staff to resident abuse and request to be relocated. The DOC indicated the investigation was determined to be unfounded because the resident was not intentionally neglected. The DOC indicated actions taken to prevent a recurrence was she spoke to the two PSW's (PSW #134 & #135) at time of investigation to remind them of the resident's toileting requirements.

3. Related to Log # 016955-17:

A critical incident report (CIR) was submitted on a specified date for neglect of a resident that resulted in harm or a risk of harm. The CIR indicated on a specified date and time, after PSW #101 provided care to resident #015 the PSW noted an injury to a specified area on the resident but did not report the injury. The resident left the room and PSW #145 and RPN #149 noticed the injury to the resident. RPN #149 questioned PSW #101 regarding the injury and indicated the injury was noted during care but unknown cause. RN #150 and the SDM were notified.

Interview with RN #150 by Inspector #570, indicated a message was left for the DOC regarding the incident and PSW #101 was immediately relieved of duty after the incident.

Interview with PSW #101 by Inspector #570 indicated the PSW was immediately relieved of duty after the incident and the DOC spoke to the PSW regarding the incident the following day. The PSW indicated he/she continued to provide care to resident #015 for three days after the incident until the DOC reassigned the PSW.

During an interview with the DOC by Inspector #570, she indicated that the investigation into the incident was completed eight days later and the outcome of the investigation was

unfounded. The DOC indicated no awareness that PSW #101 continued to provide care to resident #015 and her instruction to RPN #149 were to change the PSW's work assignment. The DOC indicated that the PSW involved with the incident should not have continued to provide care to resident #015.

The licensee has failed to take appropriate actions when the accused PSW #101 continued to provide care to resident #015 while the investigation was being completed (#570). [s. 23. (1) (a)]

4. Related to Log # 021111-17:

A complaint was received on a specified date regarding an allegation of resident to resident abuse that occurred on a specified date involving resident #036 towards resident #035. A Critical Incident Report (CIR) was also submitted to the Director on a specified date for the same allegation.

Review of progress notes for resident #035 indicated on a specified date, resident #036 was physically abusive to resident #035 resulting in an injury to a specified area on resident #035.

Review of progress notes for resident #036 indicated one to one monitoring was put in place on two consecutive shifts for a five day period after the incident. Two days after the one to one was completed, resident #036 was demonstrating responsive behaviours towards another resident.

Interview with RN #109 (charge nurse where both residents #035 and #036 reside) by Inspector #570, indicated the DOC was notified the day after the incident occurred and requested one to one intervention be put in place as resident #036 remained at risk of causing injury to other residents. RN #109 further indicated, the one to one intervention did not start until two days after the incident occurred and was supposed to be in place for three additional days but due to staff shortages, was unable to.

Inspector #570 interviewed the Director of Care (DOC) regarding appropriate actions taken following the incident of alleged resident to resident abuse involving residents #035 and #036, the DOC confirmed to the inspector that the one to one intervention did not start for resident #036 until two days following the incident. The DOC indicated to Inspector #570 that resident #036 demonstrated responsive behaviours towards another resident when the resident was supposed to have one to one intervention in place. The

DOC further indicated resident #036 was transferred to hospital for assessment related to responsive behaviours eight days after the incident occurred.

The licensee failed to take appropriate actions in response to the allegation of resident to resident physical abuse when the one to one interventions for resident #036 did not start until two days following the incident. (#570). [s. 23. (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 every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: (i) Abuse of a resident by anyone and to ensure the results of the abuse or neglect investigation were reported to the Director. (ii) Neglect of a resident by the licensee or staff and that appropriate action was taken in response to the incident., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: 1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Related to log # 009329-17 & #008920-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged resident to resident abuse.

Review of the progress notes of resident #009 and resident #010 indicated RPN #142 was notified of the allegation of resident to resident abuse by resident #010 towards resident #009 on a specified date and time by resident #009. The progress notes for resident #009 and #010 over a five month period in 2017 also indicated there were four additional incidents of alleged abuse by resident #010 toward resident #009 and were not reported to the Director.

Interview with BSO RPN #171 and BSO PSW #134 by Inspector #111 both indicated the above reported incidents were reported to the RN working that day because they were contacted by the RN's to complete a referral for resident #010

Interview with RPN #142 by Inspector #111 indicated on a specified date and time, resident #009 reported that resident #010 was abusive towards the resident and was upset. The RPN indicated the incident was not immediately reported to the RN but reported the incident to the RN at shift change.

The verbal complaint by resident #009 regarding alleged resident to resident abuse was not reported to the Director until two days later. In addition, four additional allegations of resident to resident abuse were never reported to the Director. [s. 24. (1)]

2. Re: Log # 017305-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect. The CIR was amended seven days later and indicated

the incident occurred two days before the initial reported date, at a specified date and time, when resident #014 requested to be toileted and was not provided assistance for a specified period of time by PSW #134. The CIR indicated the resident was upset as a result of the incident.

Interview with DOC and the resident, and review of the licensee's investigation by Inspector #111, confirmed the incident occurred on a specified date and time. The resident reported the incident to RN #167 later the same evening when the incident occurred. The DOC was unable to indicate why the Director was also not made aware of the allegation the following day when the Social Worker was made aware of the allegation.

Interview with PSW #134 & #135 by Inspector #111, both indicated the charge nurse and RN #167 who worked on day the incident occurred was also made aware of the incident. Therefore, RN #167 and the charge nurse were aware of the allegation but did not immediately report the allegation to the Director. [s. 24. (1)]

3. Related to Log # 016955-17:

A critical incident report (CIR) was submitted on a specified date for an improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm that occurred on a specified date and time. RN #150 was notified.

Interview with RN #150 indicated a message was left for the DOC and should have been immediately reported to the Director.
During an interview with the DOC, she indicated that she became aware of the incident the next day. The DOC indicated the incident should have been immediately reported to the Director when the evening supervisor RN #150 became aware of the incident.

Review of the CIR notes and interview of staff indicated the Director was notified of the incident seven days after the incident occurred (#570). [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 any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: 1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm., to be implemented voluntarily.

WN #8: 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 :

The licensee failed to ensure the behavioural triggers had been identified for resident #010 demonstrating responsive behaviours of a sexual nature where possible, and strategies were developed and implemented to respond to the resident demonstrating responsive behaviours of a sexual nature.

Related to Log #008920-17 & #009329-17:

Review of the health record for resident #010 indicated the resident was diagnosed with

cognitive impairment and was independently mobile in a mobility aide. Review of the health record for resident #009 indicated the resident was cognitively well and independently mobile with a mobility aide
Review of the health record for resident #019 indicated the resident was cognitively impaired and also used a mobility aide.

Review of the progress notes for resident # 009, #010 and #019 over a three month period in 2017 indicated there were eight incidents of responsive behaviours of a sexual nature demonstrated by resident #010 towards two residents (resident #009 & #019) and one incident towards resident #020.

Interview with RPN #171 by Inspector #111 indicated the incident that occurred on a specified date involved resident #010 towards resident #009. The RPN also indicated the incident that occurred on another specified date, there was two incidents of responsive behaviours of a sexual nature made by resident #010 towards resident #009 and resident #019.
Interview with RPN #127 by Inspector #111 indicated the incident that occurred on another specified date involved resident #010 towards resident #009.

Interview with BSO/ PSW #134 by Inspector #111 indicated resident #010 was referred to BSO on a specified date for demonstrating responsive behaviours of a sexual nature demonstrated towards resident #009. The BSO/PSW indicated resident #010 was then discontinued from BSO program on a specified date as there were no further documented incidents. The BSO indicated resident #010 demonstrated the responsive behaviour towards resident #009 and resident #019. The BSO/PSW indicated on a specified date, resident #010 was again seen demonstrating responsive behaviour of a sexual nature and was put back on the BSO program the same day. The BSO indicated the physician was contacted and new medications were ordered. The BSO indicated the resident was discontinued from the BSO program again two months later, as staff had not reported or documented any further responsive behaviours and one specified intervention used appeared to be effective. The BSO/PSW indicated two days later, RCAM #130 reported resident #010 was again demonstrating responsive behaviours of a sexual nature towards another resident and BSO was "frustrated" because there was no documentation regarding the incident.

Interview with RCAM #130 by Inspector #111, indicated on a specified date, RPN #166 had reported to the RCAM that resident #010 was observed demonstrating responsive behaviour of a sexual nature towards resident #020 and directed the RPN to document

the incident. The RCAM indicated the incident was reported to the BSO/PSW #134.

Review of the 24 hour unit report forms for a specified month in 2017 had one note indicating resident #010 "behaviour still present" and BSO discontinued".

Review of the Behaviour Assessment Tool (BAT) (completed on a specified date) indicated the resident demonstrated multiple responsive behaviours of a sexual nature and the trigger was unknown. Interventions included: keeping resident away from co-resident is not always possible, resident is on close monitoring (every 30 minutes), redirect resident away from unspecified residents, spend 1:1 time with residents, invite resident to programs and have resident visit more often with spouse.

Review of the "Increased Observation Forms" (monitoring) indicated the resident was inconsistently placed on every fifteen minute and/or every half hour monitoring on five separate dates in one specified month, and on three separate dates on the following month in 2017.

Review of the written plan of care for resident #010 indicated the resident displayed responsive behaviours of a sexual nature. Interventions included: allow to talk with spouse on the phone, ensure is at nursing station where staff can easily see the resident at all times when not in bed, no identifiable triggers, Registered staff to administer medication and monitor for drowsiness, when inappropriate responsive behaviour is demonstrated toward unspecified co-resident, monitor and provide activity.

The written plan of care for resident #010 had no triggers identified for responsive behaviours of a sexual nature. The strategies used were not clearly identified or inconsistently implemented, specifically with the frequency of the monitoring strategy, it was unclear in the written plan of care which specified residents were the recipient of the responsive behaviours (despite progress notes and staff interviews clearly indicating resident #009 and #019 were the recipients), the strategy of calls/visits with spouse was not clearly stated when this would occur and how, and what activities were to be provided. There were no other strategies identified related to documentation of responsive behaviours/referrals to BSO, physician, or psychogeriatric services, or when this was to occur, and to determine other strategies, where possible (111). [s. 53. (4) (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 behavioural triggers are identified for resident #010, and any other residents demonstrating responsive behaviours of a sexual nature where possible, and strategies are developed and implemented to respond to any residents demonstrating responsive behaviours of a sexual nature, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

The licensee has failed to comply with O. Reg. 79/10, subsection 73 (1) 2, review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. Subsection 71 (6) the licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m.

Related to intakes #017491-17, #006958-17 and #008774-17:

A review of the Resident's Council (RC) meeting minutes from March 20, April 4 and 17, 2017 indicated the following:
-on March 20, 2017, residents expressed that breakfast in the Cedar Unit dining room was always late, PSWs were too busy getting ready for the day and were not able to be in the dining room to feed residents and serve food. A response given to the residents on March 24, 2017, indicated that a plan had been developed to observe the nursing process in the morning to determine root causes for the late arrival.

-on April 4, 2017, there was no indication that Residents were notified of the change to the breakfast and morning snack times.
-on April 17, 2017, residents expressed that the new times for breakfast were not helping, staff were still late coming to the dining room, food was coming out cold and there was not enough time between breakfast and lunch. A response given to the residents on April 20, 2017, by Extendicare Operations Manager (former acting Administrator at time of incident), indicated that the home was trying the new breakfast time aiming at ensuring all residents get better service and will continue to monitor.

However, during review of the RC Meeting minutes for May 15, June 28, and August 21, 2017, residents continued to express to be unhappy with changes in the dining room and would like the breakfast time changed back to 0815 hours. Residents felt the service was too rushed and there was not enough time between breakfast and lunch.

Inspector #461 observed breakfast in the main dining room on August 22, 2017 and the meal started at 0845 hours. By 0945 hours, there were still a few residents eating in the dining room. On September 1, 2017, the meal service started at 0845 hours and ended at 1030 hours.

During separate interviews with the Nutrition Manger (NM) #114 and Program Director #126, both indicated the breakfast time was not reviewed with the Resident's Council prior to implementation on April 12, 2017. Program Director #126 indicated a town hall meeting was held with management and staff, and the following day residents were notified of the changes. The NM #144 provided a memo for staff dated April 12, 2017, indicating the breakfast meal service will be at 0845 hours and AM nourishment pass will be at 1030 hours.

Interview with the Extendicare Operations Manager (former acting Administrator) indicated to Inspector #571, was not able to provide any evidence of the review on the breakfast time change with the Resident's Council prior to implementation on April 12, 2017.

The licensee has failed to review the changes of breakfast time from 0815 to 0845 hours and morning snack from 1000 to 1030 hours was discussed with the Resident's Council prior to the implementation in the home on April 12, 2017. [s. 73. (1) 2.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home

has been investigated, and resolved where possible, and a response is provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately:

A. Related to Log #019022-17:

A review of the progress notes for resident #021 by Inspector #571, indicated on a specified date and time, the resident had verbally complained to staff regarding a missing mobility aide. The resident began demonstrating responsive behaviours related to their missing mobility aide. The RPN explained to the resident the mobility aide was still missing but that staff continued to look for the missing item. The only indication the verbal complaint received by resident #021 was investigated, was approximately two weeks later, when RCAM #109 documented requesting staff to search for the missing mobility aide and notified the SDM. There was no other investigation completed regarding the verbal compliant to determine how the residents mobility aide went missing.

The licensee failed to immediately investigate a verbal complaint made by resident #021 regarding a missing mobility aide (571).

B. Related to Log # 017491-17:

On a specified date, resident #012 indicated to Inspector #461, that a verbal complaint was provided to RPN #172 on a specified date, and was upset with how PSW #153 treated the resident. The resident indicated a verbal complaint was also provided to the DOC approximately one month later regarding personal care not provided by PSW #100 that occurred on the same day.

A review of resident #012 progress notes indicated on a specified date and time, PSW #153 approached RPN #172 indicating that resident #012 was upset at the PSW #153 related to personal care not provided in a timely manner and not treating the resident with respect. The progress note indicated that resident #012 requested to speak with the supervisor and RPN #172 notified RN #109. RN #109's progress notes indicated on the same day, the RN notified the resident that due to an emergency, the RN would speak to the resident later. When the RN returned to the resident's room later, the resident was not available. RN #109 re-approached the resident the following day, but the resident refused to speak to the RN. A review of the home's complaint log, indicated no documented

evidence the resident's complaint was logged.

During an interview with RN #109 by Inspector #461, the RN confirmed approaching the resident on a specified date, but the resident was not available and when RN went back to resident's room the following day, the resident refused to speak with RN. According to the RN, he/she thought the matter was settled as resident did not complain again, did not obtain any details about the verbal complaint and did not complete a complaint investigation form.

Review of the documented complaints indicated a complaint form was completed on a specified date (for a different complaint) for resident #012 after submitting a verbal complaint to the DOC at a specified time. The complaint indicated the resident was notified by RPN #155 that only PSW #100 was available on the unit for care and PSW #100 did not want to see the resident. The form was completed by the DOC and indicated she could not follow-up. The DOC interviewed RPN #155 and PSW #100 five days later. The complaint form stated the complaint was unfounded but there was no indication that the conclusion of the investigation had been reported to the resident. There was no indication of the verbal complaint received two months previously by RPN #172 regarding PSW#153.

Review of the Nursing staffing schedule indicated RPN #155 worked in the home and provided resident care on three separate dates prior to the initiation of the investigation. PSW #100 also worked in the home and provided care on two separate dates prior to the investigation. Therefore, the complaint investigation was not completed immediately.

During an interview with resident #012 on a specified date, by Inspector #461, the resident indicated a response had still not been received from the home related to the two verbal complaints regarding care by PSW #153 and PSW #100.

Interview with the Administrator by Inspector #461, indicated that staff are to follow the licensee policy related to complaints and complete the investigation complaint form, if the issue cannot be resolved within 24 hours. The Administrator indicated a response must also be given to the resident within 10 business days. The Administrator confirmed that resident #012's verbal complaints received did not have an investigation initiated or a response provided to the resident.

Interview with the DOC by Inspector #461, indicated no awareness related to initial complaint received by resident #012 and indicated she investigated the second verbal

complaint received involving resident #012 and PSW #100 but had not provided a response to resident #012.

The licensee failed to ensure that every verbal complaint was investigated (as the initial verbal complaint received was not investigated and resolved where possible), and a response was provided within 10 business days of the receipt of the complaint (as neither of resident #012's verbal complaints were provided a response). [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record was kept in the home that included: (a) the nature of each verbal or written complaint (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response, and (f) any response made by the complainant.

A. Re: log # 0035900-17:

A written complaint was received by the Licensee on a specified date from the family of resident #017. The written complaint was addressed to the home's previous administrator regarding services in the home.

Review of the Licensee's policy "Complaints and Customer Service" (RC-09-01-04) updated April 2017 indicated: under procedures, page 4 of 7, for Continuous Quality Improvement, 1. Maintain a record of all complaints and actions taken in the Compliant Log.

Review of the home's complaint log for 2017 had no documented evidence to indicate the written complaint was received from the family of resident #017 by the home or any actions taken (111).

B. Re: Log #019022-17:

A complaint was submitted to the Director regarding a missing wheelchair for resident #021. The SDM indicated that the SDM was notified on a specified date regarding the resident missing their mobility aide when the attachments did not fit. Resident #021's mobility aide had been repaired one month prior to the notification of the missing mobility aide and at that time noted the serial number on the invoice for the repair was different than the serial number of resident #021's current mobility aide. The SDM submitted a

written complaint to the licensee four months later, requesting that the licensee locate the missing mobility aide or replace the aide at the licensee's expense. A month after receiving the written complaint, the resident's mobility aide was still not located and the licensee had not replaced the missing mobility aide.

A review of the progress notes for resident #021 indicated that three weeks before the written complaint was received regarding the missing mobility aide, a care conference was held to discuss the resident's missing mobility aide. RCAM #109 indicated on that date a search would be completed and a response provided to the SDM. The following month, Behavioural Support Ontario (BSO), RPN #144 documented a referral was received for resident #021 related to the resident's aggressive behaviour in response to the missing mobility aide. RPN #144 informed the resident the missing mobility aide would be replaced by the licensee at that time.

In an Interview with Inspector #571, the DOC indicated that she reviewed the licensee's complaint log binder for 2017 and 2016 to see if a complaint was logged regarding resident #021's verbal and written complaint of a missing mobility aide and indicated there was no documented evidence that the resident's complaints were documented in the complaint log. [s. 101. (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 every written or verbal complaint made to the licensee or staff member concerning the care of a resident is immediately investigated and a response provided within 10 business days of receipt, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that the treatment orders for resident #002 were provided to the resident as specified by the prescriber.

Re: Log #014980-17:

A review of the physician and Nurse Practitioner (NP) #178 orders for resident #002 over a three month period, review of the electronic medication administration records (eMAR) and electronic treatment administration records (eTAR) indicated the following:
-on a specified date and time, an order was received for a topical treatment to be applied to a specified area. The first dose of this treatment was not administered until two days later.
-three weeks later, an order was received for a different topical treatment to be applied to a specified area daily. This order did not appear on the eTAR until six days later and was not administered.
-on the same day, an additional order was received for a different topical treatment, also to be applied to the same specified area, but at a specified time. This order did not appear on eTAR until five days later and was not administered.
-twelve days later, an order was received for a specified treatment to a specified area, applied at a specified time and as needed until resolved. The routine order did not appear on the eTAR but only the as needed treatment order and the treatment was never signed for as administered.
-on the same day, an order was received for a second treatment to a specified area to occur daily, was to be reassessed in two weeks but not to stop the treatment. The treatment was stopped 14 days later on the eTAR and not reordered until eight days later.
-the following month, approximately four weeks later, the RCAM #109 indicated the previous order was re-clarified with the NP #178.

In an interview with Inspector #571, NP #178 indicated he/she was not contacted on the specified date for re-clarification of the order as indicated above, but was approached approximately two weeks after the order was written by RCAM #109. NP #178 also indicated that the nursing staff were not applying the topical treatment as ordered and noted this when he/she reassessed the resident (571).

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 treatments are provided to residents as specified by the prescriber, to be implemented voluntarily.

WN #12: 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. (2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids. O. Reg. 79/10, s. 37 (2).

Findings/Faits saillants :

The licensee has failed to ensure that resident #021 received assistance with a medical device used for communication.

Re: Log # 019022-17:

A complaint was submitted to the Director regarding resident #021 on a specified date. Resident #021 had a medical device and could not communicate without the application of the medical device. The Substitute Decision Maker(SDM) indicated that staff were not consistently applying the medical device.

A review of the care plan indicated that resident #021 had the medical device and indicated a specified shift, was to remove the device at a specified time and store the device in a specified location.

In an interview with Inspector #571, RPN #193 indicated that the RPN on a specified shift (different from the plan of care) was responsible for applying the medical device. In an interview with Inspector #571, RPN #116 showed Inspector #571 the medical device that was kept in the specified location. In an interview with Inspector #571, RPN #107 indicated that when he/she approached the resident to apply the medical device at a specified time (not according to the plan of care), the RPN was unable to apply the medical device due to the resident receiving care and had to give medication and forgot to go back to apply the device.

The licensee failed to ensure that resident #021 received assistance with a medical device (571).

WN #13: 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).

Findings/Faits saillants :

The licensee has failed to ensure that the report to the Director included the following description of the individuals 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.

Related to log # 009329-17 & 008920-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged resident to resident abuse incident. The CIR indicated resident #009 reported to recreation staff #152 resident to resident abuse that occurred two days prior. The CIR indicated resident #009 also submitted a written complaint regarding the ongoing abuse by resident #010 towards the resident.

Review of the licensee's investigation and interview with staff indicated on a specified date, resident #009 reported to RPN #142 an allegation of resident to resident abuse by resident #010. Interview with RPN # 171 also indicated awareness of an allegation of abuse by resident #010 towards resident #009 that occurred approximately three months prior.

The CIR did not contain the names of RPN #142 or #171.

2. The licensee has failed to ensure that the report to the Director included the following description of the individuals 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.

Related to Log #017305-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect incident. The CIR indicated resident #014 reported to the Social Worker the day before the resident had requested specified care and was not provided the specified care for a period of two hours by PSW #135. The CIR only identified the name of PSW #135.

Interview of staff, the resident and review of the Licensee's investigation indicated PSW #134 was directly involved in the allegation. The Social Worker, RPN #136, PSW #134 and RN #167 were also aware of the allegation and/or discovered the incident, and their names were not identified on the CIR (111).

3. Related to compliant Log # 021111-17:

A complaint was received on a specified date regarding an allegation of resident to resident abuse that occurred the day before involving resident #036 toward resident #035.

The Director of Care (DOC) also submitted a critical incident report (CIR) for the alleged resident to resident abuse incident that occurred at a specified time. The CIR indicated that resident #036 and resident #035 were involved in the incident and a PSW staff was present and/or discovered the incident.

Inspector #570 interviewed the administrative assistance staff #194, who indicated that he/she also witnessed the resident to resident abuse incident involving resident #036 towards resident #035, resident #035 was screaming, and both residents were separated by a PSW staff. Staff #194 further indicated he/she called the registered staff where both residents reside.

During an interview, the DOC indicated she spoke to the PSW who intervened but did not take any written statement from the PSW and did not recall the PSW’s name. The DOC further indicated that she was not aware that administrative assistant staff #194 witnessed the incident. The DOC further indicated that both RPNs on the residents' unit responded to the incident and assessed both residents and also notified the residents’

families. The DOC indicated she did not take any written statement from the RPNs and that she did not include the names of the RPNs and other staff involved in the CIR (#570).

Issued on this 24th day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), CRISTINA MONTOYA (461), PATRICIA MATA (571), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2017_643111_0013
Log No. / No de registre :	002637-17, 003590-17, 004285-17, 005741-17, 006958-17, 008774-17, 009287-17, 009329-17, 013929-17, 014938-17, 014980-17, 015397-17, 016984-17, 017491-17, 018204-17, 019022-17, 020744-17, 021111-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 8, 2017
Licensee / Titulaire de permis :	CVH (No.6) GP Inc. as general partner of CVH (No.6) LP c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6
	Lesreen Thomas

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The Licensee shall prepare, submit and implement a corrective action plan to ensure there is adequate personal support services available on each unit, on each shift to meet the assessed needs of the residents. The plan is to especially ensure the residents are provided the opportunity and assistance to attend the breakfast meals, and receive assistance with their meals.

The plan should also clearly identify who will be responsible for implementing the planned actions and evaluating the effectiveness of these actions until the staffing problems linked to the program of personal support services for the home are resolved.

This corrective action plan is to be submitted via email to: OttawaSAO.MOH@ontario.ca to the attention of Lynda Brown, LTCH Nursing Inspector by November 15, 2017.

Grounds / Motifs :

1. The licensee failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

A. There were multiple complaints received through the Ministry of Health and Long-Term Care Action Line related to personal support staffing shortages impacting resident's care.

Interview with DOC by Inspector #111, indicated that the home is divided into 6 units (Aspen, Linden, Maple, Cedar, Birch and Pine). The DOC indicated Pine unit is the largest unit and has 49 residents.

Review of the Personal Support Workers (PSW) staffing schedule for a specified month in 2017 for a specified unit indicated there were a specified number of days when the unit was working short- staffed.

Interview with Nursing Administrative Assistant (Staff #120) by Inspector #111, indicated the home usually has the most short-staffing (with PSWs not at full compliment) on two specified units and usually occurs on specified shifts. Staff #120 indicated they are from sick call-ins or no-shows and usually occur over a four day period, resulting in the units working short-staffed (not working at full PSW compliment).

Interview with the Administrator by Inspector #111, indicated she identified the home was experiencing issues with PSW staffing related to a number of sick calls, no shows and vacancies. The Administrator indicated the home is working at recruiting staff to fill vacancies and disciplinary actions related to absenteeism. The Administrator indicated they also posted two memo's for staff on two specified months in 2017 related to concerns with staff no-shows and attendance concerns (111).

B. Related to log #017491-17 & # 008774-17:

Review of the Resident Council meeting minutes for 2017 by Inspector #461 indicated in a specified month, the residents expressed concerns related to inconsistency in PSW staffing, residents not receiving the same PSW on a regular basis and happening for the past six months. There was also a concern that the breakfast for a specified unit in the dining room was always late, PSWs were still getting residents ready for the day and not able to be in the dining room to provide assistance with feeding/serving, was consistently short-staffed within the nursing department resulting in inconsistency with staff providing care to residents. Review of the Resident's Council meeting minutes for four specified months, indicated the residents were unhappy with changes in the dining room times and wanted the breakfast time changed back to 0815 hours. Residents indicated the service was too rushed and there was not enough time between breakfast and lunch.

On a specified date, Inspector #461 observed the breakfast meal service (scheduled to start at 0845 and to finish by 0930 hours) in all dining rooms. The large main dining room was divided by the various home areas: Linden, Birch, Maple, and Pine. Inspector #461 observed at 0845 hours, residents were being served fluids only and the actual meal service did not commence until 0900 hours. There were residents also noted to be missing from the dining room. The breakfast meal service was still occurring at 0945 hours.

Interview with RPN #127 and PSW #141 on a specified date by Inspector #461, indicated that a specified unit had been short-staffed for the past five days. Both staff indicated on this specific date they were also short-staffed (not at full PSWs compliment) which lead to residents arriving late for breakfast. PSW #141 indicated at 0900hours, there were six residents still waiting to be taken to the dining room for breakfast.

On a specified date, during separate interviews with the Nutrition Manager #114 and Program Director #126, by Inspector #461, both indicated the breakfast start time was changed from 0815 to 0845 hours on a specified date without input from the Resident's Council. The Nutrition Manager indicated the start of breakfast time was changed because PSWs did not have enough time to bring all the residents to the dining room for breakfast.

On a specified date, Inspector #461 observed the main dining room for breakfast and noted the following: at 0845 hours, staff were noted still bringing residents into the dining room for breakfast; at 0900 hours, a PSW reported that they were still waiting for 2 residents to arrive; at 0905 hours, approximately 30 residents were sitting at their tables with just their drinks and had not yet received the hot cereal or any other breakfast items. The residents were not offered hot cereal until approximately 0920 hours; at 0910 hours, table #7 had four residents seated, including resident #022. The resident asked the Inspector for hot cereal (as there was no staff to assist) and indicated the resident had been waiting for approximately 15 minutes. At the same table, only 1 out 4 residents had received their hot cereal; at 0920 hours, the Inspector noted one resident was waiting to be brought to the dining room for breakfast. The resident was brought to the dining room at 0925 hours. There were still several residents in main dining room (specifically on Birch and Pine unit) that were still having breakfast after 0930 hours.

Interview with the Operations Manager (former acting Administrator) by Inspector #571, indicated that breakfast time was changed from 0815 to 0845 hours because when breakfast was served at 0815 hours, three quarters of the residents were not in the dining room to begin the breakfast meal. The former interim Administrator indicated with change in meal time, the breakfast meal was now completed between 0915 and 0930 hours. The former interim Administrator confirmed that an evaluation of the time change had not been completed to determine if the meal time change had been effective.

On a specified date, Inspector #461 observed the main dining room for the breakfast meal, and noted the following where residents from a specified unit were located: at 0850 hours, the residents had not yet received their fluids and there were no PSWs available to assist with meal service; at 0905 hours, residents were still arriving to the dining room and at 0910 hours, PSW #168 from the Birch unit arrived to the dining room and starting serving the residents on this unit; at 0925 hours, all four PSWs from the Birch unit were now present in the dining room. At 0930 hours, resident #012 was provided the main course of breakfast. Resident #012 stated to the Inspector the meal service at breakfast "was late almost every day". At 0938 hours, resident #025 arrived to the dining room, PSW #124 indicated that resident usually comes to the dining room independently but needs reminders, because they were short a PSW staff, the resident was forgotten in their room. Resident #025 received the breakfast meal at 0942 hours. At 1000 hours, resident #026 was served the breakfast meal, despite being seated in the dining room since 0850 hours. At 1005 hours, PSW #168 had prepared food trays for residents on isolation (resident #027, #029, and #030). The PSW has also prepared a fourth tray for resident #032. The PSW reported to the Inspector that resident #032 normally came to the dining room but the PSW did not have time to get the resident up for breakfast. PSW #168 also indicated that being short-staffed greatly affected the care provided to residents in the morning. The breakfast meal service on this date did not conclude until 1030 hours. Inspector #461 noted the morning snack was to be served at 1030 hours and lunch provided at 1200 hours. The home was not providing adequate time between the breakfast and the lunch meal to promote healthy appetite and ensure adequate nutritional intake for residents.

During an interview with the Administrator by Inspector #461, indicated awareness of the residents getting to the dining room late for breakfast and therefore not leaving the dining room until after 0930 hours. The Administrator also indicated the breakfast time change was yet to be evaluated (461).

C. Related to log # 003590-17 & # 002637-17:

Interview with resident #017 by Inspector #111 indicated the regular PSW was away for a specified period of time and ever since then, the resident has had a new PSW every day. The resident also indicated the resident was supposed to have a shower and hair washed in the morning approximately a week ago, but the staff were too late getting to the resident due to PSW short-staffing. The resident indicated the shower was refused because of an appointment at that time and was upset.

Interview with PSW #147 by Inspector #111, indicated resident #017 has a shower two days per week. The PSW indicated the resident prefers to have the shower before breakfast but the staff cannot always provide the shower at that time. The PSW indicated the shower sometimes has to be later in the morning due to PSW short-staffing (PSW not working at full compliment) and the resident will then refuse (111).

D. Related to log # 017305-17:

A critical Incident Report (CIR) was received by the Director on a specified date for an alleged staff to resident neglect. The CIR indicated resident #014 had reported a verbal complaint the resident was not toileted as requested two days prior for a period of two hours.

Review of the resident #014 health record, review of the licensee's investigation and interview of staff (PSW #134 & #135) by Inspector #111, indicated on a specified date and time, resident #014 had rang the call bell and requested assistance with toileting. Resident #014 required two staff assistance with a mechanical lift. PSW #134 indicated he/she would get assistance and the mechanical lift and return but did not return until approximately two hours later with PSW #135. The resident was incontinent, was upset and crying as a result. PSW #134 indicated that they were working short-staffed (PSW not working at full compliment) that evening and had to wait for PSW #135 to be able to assist with toileting (111).

E. Related to log # 014938-17:

An anonymous complaint was received by the Director regarding the home

always working short-staffed (PSWs not at full compliment), especially in the evenings, and on the unit with 49 residents.

Interview with PSW #140 on a specified unit by Inspector #111, on a specified date indicated the unit was working short-staffed today (PSW not at full compliment) and has worked short-staffed for the last five days in a row. The PSW reported to Inspector #461 that the staff were late getting residents to the dining room for breakfast (not until after 0900 hours) as a result. In an interview with PSW #140 on a specified date by Inspector #111 indicated the same specified unit has been short-staffed on a specified shift every day for last two weeks.

Interview with PSW #123 & #125 and RPN #121 on a different specified unit by Inspector #111 on a specified date, indicated they frequently work short- staffed, usually 3-4 times per week. The PSW's indicated they were working short-staffed again today. The PSW's indicated they were a half hour late getting the residents down to the dining room for lunch as a result. The PSW's indicated one PSW had to remain on the floor to assist with toileting during the meals so they only had 3 PSW's to assist with feeding 41 residents.

Interview with the Administrator by Inspector #111 indicated she identified the home was experiencing issues with PSW staffing related to a number of sick calls, no shows and vacancies. The Administrator indicated the home is working at recruiting staff to fill vacancies and disciplinary actions related to absenteeism. The Administrator indicated they also posted two memo's for staff in two specified months related to concerns with staff no-shows and attendance concerns.

The severity of this non-compliance indicated that there was potential for harm/risk as the organized personal support staffing was not meeting the needs of the residents, and the scope was a demonstrated pattern as there was two out of six resident units where the PSWs were noted not working at full compliment. This impacted the resident care by the following: resident #014 was not toileted as requested for a period of two hours, resulted in the resident being upset; several residents on two specified units were not receiving their breakfast meals in the dining room and/or within the designated meals times (despite the meal time being changed to a later time). Not providing adequate time between the breakfast, morning snack, and the lunch meal does not promote healthy appetite and ensure adequate nutritional intake for those residents; and resident

#017 who requested showers to be provided before breakfast to accommodate an appointment, was occasionally not receiving a shower on those days when PSWs were work short-staffed (111). (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 30, 2018

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 245. The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act.
O. Reg. 79/10, s. 245.

Order / Ordre :

The licensee shall immediately reimburse all residents who were charged the $5.00 portering fee for advanced foot care since June 13, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are not charged for goods and services that they are required to provide using funding.

Related to Log #014980-17:

A review of the Family Council meeting minutes for a specified date, by Inspector #571 indicated that foot care was an unfunded service and in future, a charge of twenty five dollars would be charged to those residents and the service would be provided every eight weeks. The minutes indicated the service was optional and another provider could be chosen. Review of a memo, with a specified date, indicated that effective June 13, 2017, residents would be charged for foot care services as historically, the home provided the unfunded service at no charge but were no longer able to continue.

In an interview with Extendicare Operations Manager (former acting Administrator) by Inspector #571, clarified that the memo and Family Council meeting minutes were referring to advanced foot care only. The Operations

Manager indicated that the licensee was previously providing advanced foot care at no cost to the residents and since advanced foot care was an unfunded service, the licensee decided to hire an outside advanced foot care nurse to provide advanced foot care services to residents. The Operations Manager indicated the total advanced foot care charge was thirty five dollars which included: thirty dollar charge for the foot care nurse and five dollar charge that was used to pay a PSW (employee of the home) to porter the residents to a central location in the home for the foot care service.

In an interview by Inspector #571 with the Administrator, indicated that the advanced foot care was provided in each resident room rather than in a central location. The Administrator indicated, the advanced foot care service by an outside provider was a new process and the licensee was still working on the process.

The licensee provided a list to Inspector #571 that indicated 84 residents had been charged and paid for the 35 dollar advanced foot care, which included the five dollar portering charge, since June 13, 2017.

The licensee receives funding through the nursing and personal care envelope from the Ministry of Health and Long Term Care. Such funding would include portering of residents to all areas within the long term care home. Therefore, the five dollar charge for portering is prohibited (571). (571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a corrective action plan to ensure:
1) All RCAMs, RNs and RPNs are retrained on the licensee's skin and wound program,
2) The clinically appropriate assessment tool (Bates-Jensen) is completed as per the Licensee's skin and wound Care Program,
3) The Wound Care Lead conducts wound care rounds, and quality improvement reviews as per the licensee's skin and wound care program, and promptly responds to referrals from the nursing staff with any new or changes in skin and wounds.
4) Referrals are completed to specialized wound services (ET Therapy) and are timely and effective,
5) Communication that occurs between nursing staff, the physician or Nurse Practitioner(i.e. RPN to RN, and RN to RCAMs), meaningful information is shared when residents are having a new, change or deterioration of any alteration in skin and/or wounds.
5) RPN's complete the wound surveillance records as per the Licensee's skin and wound care program.

The corrective action plan is to be submitted via email to: OttawaSAO.MOH@ontario.ca attention Lynda Brown, LTCH Nursing Inspector by November 15, 2017.

Grounds / Motifs :

1. The licensee failed to ensure that the skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions, was fully implemented in the home.

A review of the licensee's Skin and Wound Program: Prevention of Skin Breakdown (RC-23-01-01) and Wound Care Management policy (RC-23-01-02), last updated February 2017 indicated the program gives directions including the following:
- RC-23-01-01: to designate a Wound Care Lead to coordinate the program and work with the interdisciplinary team to ensure program implementation and effectiveness; conduct wound rounds and quality improvement reviews regularly. Appendix 1 directs the nurse to inform Wound Care Lead, Physician/Nurse Practitioner (NP) of any new and/or worsening skin breakdown and as need; complete surveillance as required.

-RC-23-01-02: the Nurse or Wound Care Lead to: promptly assess all residents exhibiting altered skin integrity on initial discovery; use a Bates Jensen Wound Assessment Tool for pressure ulcers/venous stasis or ulcer of any type; use an Impaired Skin Integrity Assessment Tool for all other skin impairments (i.e., skin tears, rashes, reddened areas, bruises); monitor resident skin condition with each dressing change, re-assess at minimum weekly; re-evaluation and documentation of treatment with creams and other medicated preparations should occur at minimum weekly; initiate one Bates-Jenson Wound Assessment for each open area/wound; complete the Bates-Jensen Assessment if condition worsening or not improving as expected, but at a minimum every seven days; photograph pressure ulcers and complex wounds as needed to track healing and assess treatment effectiveness;

Related to Log # 016984-17:

Resident #005 was admitted to the home with diagnoses that included alteration in tissue perfusion, history of skin breakdown and wounds to specified areas. The resident was hospitalized on two separate occasions related to wounds since admission. A review of the clinical health record over a seven month period, from the time of admission, indicated the following:
-the following month after admission, the resident's wounds were assessed by an Enterostomal Therapy (ET) Nurse and new treatments were ordered for wounds to specified areas.
-the following month, the dressings and the wounds, on specified areas, were noted to have a foul smell. A week later, moderate, foul smelling drainage was noted from specified wounds. A week later, a specified wound had a change in the amount and type of discharge. A week later, the resident was assessed by the ET Nurse and recommended a new treatment, and suggested antibiotics for specified wounds due to infection.
-the following month, resident was reassessed by the ET Nurse, the resident was sent to hospital due to skin related changes to specified areas and treated with antibiotics. The resident returned from hospital a month later and continued the antibiotic therapy. A week later, another wound to a specified area was noted to be deteriorating. A week later, dressing changes to specified wounds indicated excessive bleeding and the Physician was notified. The Physician discontinued specified treatments.
-two days later, a specified wound was noted to further deteriorate and was reported to the Resident Care Area Manager (RCAM). A referral was made to the Wound Care Lead.

-three days later, a Weekly Impaired Skin Integrity Assessment was completed and indicated the wound over one specified area had deteriorated further, and identified four other areas with altered skin integrity.
-three days later, a Bates-Jensen Assessment was completed and indicated the wound to a specified area had deteriorated further.
-a week later, the Weekly Impaired Skin Integrity Assessment indicated the wound to a specified area was larger and further deteriorated.
-a week later, a Bates-Jensen Assessment indicated the wound to a specified area was larger and the four other wounds to specified areas were also getting larger. There was also two additional wounds noted.
-a week later, all wounds were noted to have large amount of foul smelling drainage and the resident was crying out in pain. The Physician was contacted and the resident was transferred to hospital for assessment.

A review of the clinical health records for resident #005 indicated over a seven month period in 2017, the Bates-Jenson skin assessment was completed as follows:
-on a specified date, two assessments were completed, one for multiple wounds to a specified area and one for multiple wounds to another specified area. The Inspector was unable to determine what the measurements were for which wounds and descriptions of the wounds due to multiple wounds listed.
-the following month, two assessments were completed, one for multiple wounds to a specified area and one for multiple wounds to another specified area. The Inspector was unable to determine what the measurements were for which wounds and descriptions of the wounds due to multiple wounds listed. o
-two months later, one incomplete assessment was completed for a specified area which was lacking wound measurements.
-six days later, one assessment was completed for a specified area with multiple skin breakdown to specified areas.
-the following month, one assessment was completed for a specified area with specified measurements.
-the following month, one assessment was completed for five different specified areas with specified measurements. The specified areas measured larger than the previous month with additional areas.
-the following month, one assessment was completed for multiple wounds to two specified areas.
-six days later, one assessment was completed for two wounds to a specified area and one assessment for five wounds to another specified area.

In an interview with Inspector #571, RPN #117 indicated that resident #005 had returned from the hospital on a specified date with a wound to a specified area and described the wound. RPN # 117 indicated no awareness of requirement to complete weekly Bates-Jensen assessments for specified types of wounds. RPN #117 indicated the RCAM/Wound Care Lead (#130) was notified of the wound.

In an interview with Inspector #571, RCAM/Wound Care Lead (#130) indicated that resident #005 was admitted to the home with multiple wounds so he/she arranged to have an Enterostomal Therapy (ET) Nurse come in to assess resident #005's wounds monthly. The ET Nurse did not assess the resident in one specified month as the home was in outbreak. RCAM #130 indicated that he/she had just become aware that the Bates-Jensen wound assessments had to be completed for all wounds, not just pressure ulcers. RCAM #130 indicated that the Skin and Wound Program policy was new and that he/she is still learning about the Program. In addition, he/she indicated the nurses were to track all wounds on the wound tracking form but that the forms were not always completed. The RCAM indicated when a resident had a new, challenging or worsening wound, staff were to submit an electronic referral to the wound care lead but he/she was not always able follow up on the referrals right away. The RCAM indicated wounds were not photographed in the home.

There was no documented evidence to indicate the Bates-Jensen weekly skin assessment (the clinically appropriate assessment instrument) was completed 17 times during a five month period for resident #005's multiple wounds. The Bates-Jensen assessments were not completed weekly for each of the wounds that resident #005 had, it was not clear when the resident started to display signs and symptoms of a specified tissue alteration diagnosis and this diagnosis was not discovered until the NP completed a monthly assessment of the resident and sent to the hospital. Also, it was unclear what the status of resident #005's wounds were from week to the next week and exactly where the wounds were located, as the licensee was not ensuring that registered nursing staff were using a Bates-Jensen tool weekly for each wound.

There was no documented evidence that photographs were taken of any of resident #005's wounds. There was no documented evidence to indicate that the physician or Nurse Practitioner was notified when resident #005's wounds displayed signs and symptoms of infection on a specified date (wounds were noted to be foul smelling), until the ET Nurse completed the monthly wound

assessment approximately three weeks later and recommended antibiotics. There was no documented evidence to indicate that the physician or Nurse Practitioner was notified when resident #005's wounds were increasing in size (deteriorating). The licensee failed to ensure that their interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was implemented.

Since resident #005's admission to the home, resident #005 developed and/or had multiple, worsening wounds and included infection to her bilateral arms and legs that resulted in two hospitalizations. In addition, a wound over the left Achilles tendon deteriorated from 4 cm long by 3 cm wide on June 1, 2017, to 12cm by 7.5 cm with an exposed tendon on July 9, 2017. The licensee failed to ensure that correct documentation, assessment or follow-up was conducted as per their Skin and Wound Program. A Compliance Order was issued as a result under O. Reg. 79/10, s. 48 (1) 2., due to the severity and negative outcome towards resident #052. [s. 48. (1) 2.] (571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 15, 2017

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

1) Ensure that resident #014 and #021 are provided with assistance and supervision with toileting according to the care set out in their plan of care; and assistance and supervision is provided to any other residents based on their assessed needs, related to toileting.

2) Develop and implement a monitoring tool to ensure that all residents, including resident #014 and #021, are provided with assistance and monitoring with toileting according to their assessed needs.

3) Ensure that supervision from nursing supervisors/managers is heightened, when the personal support staffing is not at full staffing levels, to ensure that all residents are provided with proper care, assistance and supervision with all care needs, according to the planned care.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #021 as specified in the plan, related to toileting.

A. Related to log #017305-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect incident towards resident #014. The CIR indicated two days before at a specified time, the resident was not toileted for a specified period of time.

Review of the written plan of care for resident #014 (in place at time of incident) under toileting/continence indicated: the resident was incontinent, wears an incontinence product, requires two staff assistance with mechanical lift and the resident to be reminded to use call bell when assistance is required.

Review of the licensee's investigation, review of resident #014's health record and interview of staff indicated: on a specified date and time, the resident had rang for assistance with toileting. PSW #134 responded to the call bell and informed the resident she/he would have to get the mechanical lift and a co-worker (PSW #135) to assist with toileting. The PSW indicated PSW #135 was unable to return to assist the resident for a specified period of time. The PSW returned to the resident approximately two hours later and the resident was upset as a result. PSW #134 indicated no other staff were asked to provide assistance with toileting despite two other PSW's working on the unit and indicated they were working short-staffed that evening as well (111).

B. Related to Log # 019022-17:

A review of the written care plan for resident #021 (at time of incident) indicated under toileting, an intervention (initiated prior to the incident) directing staff not to leave the resident unattended on the toilet. An intervention of an alarming device was also to be used to alert staff when the resident was going to the bathroom.

Review of the progress notes for resident #021 indicated that on a specified date and time, resident #021 was found sitting on the bathroom floor, with an injury to a specified area. The PSW reported the resident had been left on the toilet unattended by a staff member.

In an interview with Inspector #571, RPN #192 indicated resident #021 had history of multiple falls. The RPN indicated on a specified date, when resident #021 sustained the fall, the resident was left unattended on the toilet by a PSW.

On a specified date and time, Inspector #571 observed resident #021 sitting in a mobility aide in his/her room. The resident then proceeded to enter the bathroom and attempted to self-transfer to the toilet. The alarming device did not activate and the Inspector noted the alarming device was turned off.

In an interview with RPN #179 by Inspector #571, indicated that she/he has to

remind staff all the time to not turn off the alarming device.

The licensee failed to ensure that the care set out in the plan of care related to toileting was provided to the resident as specified in the plan, specifically, the alarming device and supervision with toileting.

A Compliance Order was warranted as the Licensee has had ongoing non-compliance with ensuring resident's plan of care were provided to residents, as specified in their plan, related to LTCHA, 2007, s.6(7). The Licensee was issued a Written Notification (WN) for s.6(7) under Compliance Order (CO)#002 for LTCHA, 2007, s.19 (1) on June 3, 2015 during a critical incident inspection (#2015_360111_0014) and was returned to compliance on November 30, 2015. LTCHA, 2007, s.6(7) was issued as a WN on June 8, 2015 during a critical incident inspection (#2015_293554_0009). LTCHA, 2007, s.6(7) was issued as a (CO) on July 5, 2016 during the RQI inspection (#2016_327570_0014) and was returned to compliance on January 9, 2017. The Licensee was issued a (WN) for LTCHA, 2007, s.6(7) on October 4, 2016 during a complaint inspection (#2016_327570_0022). The Licensee was also issued a (WN) for s.6(7) under Compliance Order (CO)#003 for LTCHA, 2007, s.19 (1) on January 16, 2017 during a RQI inspection (#2017_360111_0001) with a compliance date of June 30, 2017. [s. 6. (7)] (571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2017

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee shall:
1) Ensure that any staff member who witnesses, suspects or receives an allegations of abuse and/or neglect of a resident by anyone, immediately reports the incident to the Director with the support of their immediate supervisor.
2) Ensure when the Nursing Supervisors/Managers/Administrator/DOC/or delegate are made aware of an alleged, suspected or witnessed incident of abuse and/or neglect, they immediately investigate the incident(s).
3) Ensure that all of the investigations are completed as per the home's Prevention of Abuse and Neglect policy, specifically,
a) residents are assessed and actions are taken to protect the residents, and this is documented in the residents health record,
b) the investigation toolkit is used, to ensure the investigation is completed thoroughly
c) the evidence linked to the investigation is kept in a consistent, secure location and the outcome of the investigation is clearly documented.
d) immediate actions are taken with those involved in the allegations, as per the licensee's policy.

Grounds / Motifs :

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

Review of the Licensee's policy "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" (updated April 2017):
-(RC-02-01-01), page 3/8, promptly investigate resident to resident altercations,

complaints and unexplained bruising or injuries to determine root cause and put in place measures to prevent recurrence.
-(RC-02-01-02), anyone who witnesses or suspects abuse or neglect of a resident by another resident, staff or other person must report the incident. Staff must complete an internal incident report and notify their supervisor. The Nurse would then call the Manager on-call immediately upon suspecting or becoming aware of abuse or neglect of a resident.Management will promptly and objectively report all incidents to external regulatory authorities.On page 2/5, the Administrator has the authority to place an employee on Leave of Absence with pay, pending the results of the investigation. On page 3/5, all staff are to ensure the safety of and provide support to the abuse victim(s) through completion of full assessments, a determination of residents needs and a documentation plan to meet those needs. Other specialized supports to resident/families involved in the alleged incident (e.g. social work counselling). In case of physical and/or sexual abuse, accurate detailed descriptions of injuries/condition are documented in the resident chart.
- (RC-02-01-03), page 3/5, the Administrator or designate, immediately advise the employee that they are being removed from the work schedule, with pay, pending the investigation, the investigating manager/supervisor will: fully investigate the incidents in keeping with the step as outlined in the investigation toolkit; Under Appendix 2, page 2/8, collect employee statements; page 4/8, prior to the start of your interviews, create a list of all witnesses who have direct or indirect knowledge of the incidents, take note to add them to you interview list; page 5/8, have the employee sign off on the notes. This places the onus on the note taker to write clear, legible and detailed notes. Write the date and time of the interview as well as who was present in the room during the interview; on Page 8/8, collect all documents from the investigation and organize it for filing in an appropriate, secure and confidential location.

A. Related to log #017305-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect incident towards resident #014. The CIR indicated on a specified date and time, resident #014 reported to the Social Worker the resident had requested to be toileted and was not toileted for approximately four hours by PSW #135. The CIR was amended eight days later and indicated the investigation revealed that the incident actually occurred three days before the CIR was submitted, involved PSW #134 and the resident was not toileted for two hours. The CIR indicated the resident was upset and crying

as a result of the incident. The CIR indicated the allegation was unfounded.

Review of the progress notes of resident #014 had no documented evidence of the incident that occurred on the specified date and time until three days later when a progress note was completed by the Social Worker (SW). The SW indicated they were notified of a verbal complaint by resident #014, the resident was visibly upset and crying. The SW indicated the resident also reported the staff were not treating the resident with respect and dignity and requested to be relocated. The SW indicated the DOC, Administrator and RCAM were notified of resident's concerns.

Review of the staff schedule indicated PSW #134 continued to provide resident care on four specified dates prior to the initiation of the investigation.

Review of the licensee's investigation and interview of staff indicated resident #014 reported the allegation to the Social Worker two days after the incident occurred and the resident requested to be relocated. The resident informed the Social Worker the allegation was also reported to the night RN (RN #167) the same day the incident occurred. The Social Worker emailed the allegation to the DOC and did not call the on-call manager/supervisor as per the licensee's policy. The investigation notes were completed by the DOC and were not signed by the staff. The notes indicated PSW #134 and #135 were interviewed eight days after the incident was reported and continuing to provide care to residents on specified dates. PSW #134 reported they were working short staffed when the incident occurred and had to wait for approximately two hours for PSW #135 to provide assistance with toileting and the resident was upset. PSW #134 indicated the incident was reported to the charge nurse the same time the incident occurred. The licensee's investigation indicated no other staff were interviewed regarding the allegation (other PSW's, RPN and the RN that worked when the incident occurred). The DOC indicated the SDM was notified of the outcome of the investigation eight days later (when the investigation was started) and determined the allegation was unfounded. The DOC confirmed there was no investigation into the other allegations reported to the Social Worker by the resident and request to be relocated.

Interview with DOC and Administrator by Inspector #111 indicated the expectation of all staff, including managers is to immediately assess the resident, provide emotional support as needed, registered staff to document the incident and all managers/supervisors to utilize the investigation toolkit for

completing all investigations. They both indicated this policy was not complied with related to this allegation of staff to resident improper care, despite determining the allegation was unfounded (111).

B.Related to Log # 016955-17:

A critical incident report (CIR) was submitted on a specified date for an improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm that occurred seven days prior at a specified time. The CIR indicated PSW #101 provided care to resident #015, put the resident in bed and noticed an injury to a specified area on the resident but did not report the injury. PSW #145 and RPN #149 observed the injury to a specified area. RPN #149 questioned PSW #101 regarding the injury to determine cause and the PSW reported the injury was noted when after providing care but unknown cause. RN #150 and the SDM were notified.

Interview with PSW #101 indicated the PSW was relieved of duty the same day the injury was noted to resident #015. The PSW indicated the DOC questioned the PSW the following day. The PSW indicated she/he then continued to provide care to resident #015 on three separate dates until the DOC changed the work assignment which would not include resident #015.

During an interview with the DOC, she indicated that when conducted interviews she took notes in a note book. The DOC further indicated, she should have used the Complaint Investigation Form when conducting and documenting the interviews as part of the investigation. A later interview with the DOC, she indicated that the investigation into the incident was determined to be not founded. The DOC indicated no awareness that PSW #101 continued to provide care to resident #015 that her instruction to RPN #149 were to change the PSW's work assignment. The DOC indicated the PSW involved with the incident should not have continued to provide care to resident #015. The DOC indicated that she became aware of the incident the next day and the incident should have been immediately reported to the Director when RN #150 became aware of the incident.(570)

Review of the licensee's investigation notes provided to Inspector #570 included written notes only. The written notes had no date and time identified to indicate when the interview took place and there were no employee signature on the notes.

During an interview with the Administrator by Inspector #570, she indicated that it is the expectation that managers should use the designated investigation forms when conducting investigations related to complaints and abuse allegations.

The licensee has failed to comply with the written policy that promotes zero tolerance of abuse and neglect of residents specific to conducting investigations (#570).

C. Related to Log #005854-17:

A critical incident report (CIR) was received by the Director on a specified date for an alleged staff to resident abuse. As per CIR notes, a family member of a co-resident reported a PSW was providing improper care to resident #004. The CIR indicated the allegation was determined to be unfounded. The CIR was completed by the Extendicare Long-Term Care consultant.

Review of the licensee's investigation contained a Client Feedback Log that indicated the investigation was completed on a specified date and concluded that the allegation of abuse was unfounded. There was no other documents from the investigation (i.e. interviews/statements).

Interview with the Extendicare Long-Term Care consultant by Inspector #570 indicated that she could not locate the investigation notes and that all records pertaining to the investigation should have been documented and kept in a secure place (570).

D. Related to Log # 018204-17:

A critical incident report (CIR) was submitted to the Director for an alleged resident to resident abuse incident that occurred on a specified date and time. The CIR indicated resident #012 was abusive towards resident #013.

Review of the licensee's investigation notes provided to Inspector #570 included a one page written note. The written note had no date and no time identified to indicate when the interview took place. Further, there was no employee signature on the note.

During an interview with the DOC by Inspector #570, she indicated that when conducted interviews she took notes in a note book. The DOC further indicated, she should have used the Complaint Investigation Form when conducting and documenting the interviews as part of the investigation.
During an interview with the Administrator by Inspector #570, she indicated that it is the expectation that managers should use the designated investigation forms when conducting investigations related to complaints and abuse allegations.

The licensee has failed to comply with the written policy that promotes zero tolerance of abuse and neglect of residents specific to conducting investigations. (#570).

A Compliance order was warranted as the Licensee has had ongoing non-compliance with ensuring the policy to promote zero tolerance of abuse and neglect of residents, which includes investigations are to be completed immediately and appropriate actions are taken, and allegations or suspicions are immediately reported to the Director. In addition, the licensee's failure to immediately report/investigate and take appropriate actions, increases the severity of harm to the residents. The licensee was issued LTCHA, 2007, s.20(1) on the following dates: a Written Notification (WN) under Compliance Order (CO) for LTCHA, 2007, s.19 (1) on June 3, 2015 during a critical incident inspection (#2015_360111_0014) and was returned to compliance on January 15, 2016; a (WN) under Compliance Order (CO) for LTCHA, 2007, s.19 (1) on November 16, 2015 during the RQI inspection (#2015_365194_0028) and was complied with on August 5, 2016; a (WN) under the (CO) for LTCHA, 2007, s.19 (1) on January 16, 2017 during the RQI inspection (#2016_360111_0001). [s. 20. (1)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

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

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

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

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

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

Issued on this 8th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : LYNDA BROWN

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 26, 2018	2018_694166_0005	001759-18	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

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

CAROLINE TOMPKINS (166), BAIYE OROCK (624), CHANTAL LAFRENIERE (194), DENISE BROWN (626), SAMI JAROUR (570), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 5,6,7,8, 9,12,13,14,15,16, 20,22,23, 2018

Critical Incidents-(CIR)
log #021210-17, related to reporting a disease outbreak,
log# 000036-18, related to a mechanical breakdown,
log #021670-17, related to allegations of resident to resident abuse,
log# 027982-17, related to allegations of resident to resident abuse,

log #022326-17, related to allegations of staff to resident abuse
log #025587-17, related to allegations of staff to resident abuse
log #028502-17, related to allegations of staff to resident abuse
log #032172-17, related to allegations of staff to resident abuse,
log #003241-18, related to allegations of staff to resident abuse,
log #027012-17, related to falls
log #02809-17, related to falls
log #002371-18, related to falls
log #002546-18, related to falls,
Complaint log #027205-17, related to resident care
Complaint log #001472-17, related to resident care
Follow up to order #001, log #026760-17,
Follow up to order #002, log #026761-17,
Follow up to order #003, log #026762-17,
Follow up to order #004, log #026763-17,
Follow up to order #005, log #026764-17,
The above listed were inspected concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family, representatives from the Residents' and Family Council, the Social Worker(SW), Occupational Therapist(OT), Physiotherapist Assistant(PTA), Program Manager, Environmental Manager, Resident Assessment Instrument Coordinator(RAI), Behaviourial Support Ontario team member(BSO), Personal Support Workers (PSW), Registered Practical Nurses(RPN), Registered Nurses(RN), Resident Care Area Managers(RCAM), Director of Care(DOC), Director of Clinical Care, Director of Quality, Executive Director(ED) Corporate Nursing Consultant and Corporate Regional Directors.
During the course of this inspection, the inspectors toured common and resident home areas, observed meal and snack services, staff to resident interactions during the provision of care, resident to resident interactions, observed medication administration, infection control practices. The inspectors reviewed clinical records, educational records, staffing compliment records, the licensees' investigations documentation and the licensee's policies related to zero tolerance for abuse, medication orders and administration, skin and wound and staffing.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #005	2017_643111_0013	194
O.Reg 79/10 s. 245.	CO #002	2017_643111_0013	570
O.Reg 79/10 s. 48. (1)	CO #003	2017_643111_0013	166
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #004	2017_643111_0013	624
LTCHA, 2007 S.O. 2007, c.8 s. 8. (1)	CO #001	2017_643111_0013	166

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of three high risk medication incidents for the month of August 2017 (discussed at the Professional Advisory Committee Meeting in September 2017) and three high risk medication incidents for the month of January 2018 were inspected by inspector #194.

Review of a medication incident report involving resident #054 indicated RPN #142 did not administer a prescribed medication to resident #054. The medication incident report indicated there was no negative outcome to resident #054 as a result of the medication error.

Review of resident #054's physician's orders indicated the medication was ordered to be administered every 8 hours.
Review of resident #054's Medication Administration Record (MAR) indicated there was no registered nurse signature to indicate that the medication was administered to the resident.

RPN # 142 was interviewed by inspector #194 and indicated an unawareness that a medication error involving resident #054 had occurred.

Review of a medication incident report involving resident #057 indicated that an incorrect dosage for a medication ordered by the physician was administered to resident #057. The medication incident indicated resident #057 did not have negative outcome as a result of the medication error.

Review of a medication incident report involving resident #073 indicated a prescribed medication was not administered to resident #073 for four consecutive days.
RPN,s #108, #143, #144 and #145 were identified as being the staff involved in the medication incident. The medication incident report indicated there was no negative outcome to resident #073 as a result of the incident.

Interview with RPN #108 and RPN #143, indicated RCAM #117 reviewed the 8 rights of medication administration, post medication incident with the registered staff involved. [r.131.(2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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 resident #022, who demonstrated responsive behaviours, the strategies that had been developed were implemented to respond to these behaviours,

Related to log#028502-17

A Critical Incident Report (CIR) was submitted to the Director reporting an alleged incident of staff to resident abuse.
Review of the CIR documentation indicated, PSW #130 was walking by resident #022's room and observed resident #022 displaying responsive behaviours.
The PSW covered the resident with a sheet and left to assist in the dining room. When PSW #130 returned to provide care, resident #022 continued to display responsive behaviours. The PSW continued to provide resident care even as the resident continued to display responsive behaviours,
The plan of care for resident #022, related to responsive behaviours indicated resident #022, was cognitively impaired, and displayed resistive behaviours towards staff when care was provided.
Interventions for the responsive behaviours for resident #022, indicated that staff were to leave the resident when redirection was ineffective and return in 10 minutes, and if behaviours continued staff were to have another staff attempt the care.
Interview with PSW #130, conducted by inspector #194, related to care provided to resident #022, indicated that care continued to be provided while resident #022 was agitated.
PSW #130, indicated that care was provided by holding the resident's hands with co worker PSW #131 present to ensure that hygienic care was provided prior to the resident receiving visitors.
PSW #130 indicated being aware of the resident's responsive behaviours and the strategies identified in the plan of care but continued to provide care to resident #022, while the resident displayed responsive behaviour contrary to the strategies that had been developed related to resident's responsive behaviour management strategies. [s. 53. (4) (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 the strategies that have been developed related to the management of responsive behaviours for resident #022 are carried out, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s.101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).

Findings/Faits saillants :

1. The licensee has has failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under this Act.
On November 15, 2017, compliance order (CO)#003, made under O.Reg.79/10, s.48(1) during Inspection #2017_643111_0013 was served.
The licensee must be compliant with s.48(1)2
Specifically:
1) All RCAMs, RNs, and RPNs are retrained on the licensee's skin and wound program. The compliance date was December 15, 2017.
Review of the education program schedule, the registered staff compliment, interview with registered staff and interview with the Director of Care indicated at the time of this inspection there were 51 registered staff employed in the home. There were 8 out of 51(16%) staff left to be trained.

The licensee has failed to complete section #1 of CO#003, all RCAMs, RNs, and RPNs are retrained on the licensee's skin and wound program. [s. 101. (3)]

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 compliance with the LTCHA , specifically, section 1 of CO #003, related to the retraining on the licensee's skin and wound program for all RCAMs, RPNs and RNs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident is reported with immediate action taken to assess the resident's health. All medication incidents are reported to the resident, the resident's Substitute Decision Maker(SDM), the DOC, the Physician and the pharmacy.

The Executive Director and the Director of Care, who were aware of the medication incidents are no longer at the home and unable to speak to the identified incidents.

Review of a medication incident report involving resident #054 indicated RPN #142 did not administer a prescribed medication to resident #054. The medication incident report indicated there was no negative outcome to resident #054 as a result of the medication error.
Review of the resident's clinical health record did not provide evidence, the resident's SDM, Physician or pharmacy had been notified of the medication error.

RPN #142 was interviewed by inspector #194 and indicated the RPN had not been informed of the medication error involving resident #054. RPN # 142 indicated that neither RCAM #146 or the former DOC addressed the medication error.

RCAM #146 indicated to inspector #194 being able to recall the medication incident report and that mentoring related to review of the 8 rights to medication administration would have been reviewed, RCAM #146 indicated having not documented any of the education on the medication incident report.

Review of a medication incident report involving resident #056 indicated, two tablets of a controlled medication were found in a medication cup in the medication cart. Review of the Medication Administration Record for resident #056 indicated the controlled medication had been signed off by a registered staff as being administered to the resident.
The medication incident report indicated RPN #128 and #127 were both interviewed during the licensee's investigation and it was undetermined which RPN did not administer the medication that was found in the medication cart.

During an interview with inspector #194, RPN # 128 indicated being informed of the medication error by RCAM #137. RPN #128 indicated that no education or mentoring took place and no one else followed up with the RPNs related to the medication incident.

Review of the medication incident report involving resident #056 indicated no evidence to support that corrective action was initiated related to the medication incident. [s. 135. (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 ensure that every medication incident involving a resident and every adverse drug reaction is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written care plan for resident #052 sets out the planned care for the resident related to the use of commode chair for toileting.

Related to Log #002546-18

A Critical Incident Report (CIR) was submitted to the Director reporting that resident #052 had fallen and had sustained an injury.
Review of the CIR indicated, PSW #138 noted resident #052 was leaning forward while sitting on a commode . The resident was lowered to the floor by PSWs #138 and #119.
The plan of care reviewed did not reveal that the resident used a commode chair. In addition, there was no indication of any directions to staff regarding using the commode chair.

During separate interviews, PSW #112 and #138 both indicated to Inspector #570 that they had used the commode chair resident #052 once or twice a week. The PSWs indicated that about two weeks prior to the resident's fall, RPN #111 informed them not to use the commode chair for resident #052 due to safety concerns.
During an interview, RPN #111 confirmed to Inspector #570 that the written plan of care for resident #052 did not include the use of the commode chair for the resident.

The licensee did not ensure that the written care plan for resident #052 set out the planned care for the resident, specific to the use of a commode chair. [s. 6. (1) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

Related to Log #028091-17

Critical Incident Report was submitted to the Director reporting that resident #041 had fallen an had sustained an injury.

Review of the CIR indicated, resident #041 was found on the floor and was transferred to hospital for further assessment.
Resident #041 had a significant change in level of care post fall.

During an interview, the DOC confirmed to Inspector #570 that the Critical Incident Report relating to resident #041's fall was not submitted to the Director within one business day.
The licensee did not notify the Director of the incident involving resident #041 until two days after the resident's significant change in level of care related to the incident.

Related to Log #002371-18

Critical Incident Report was submitted to the Director reporting that resident #043 had fallen an had sustained an injury.
Review of the CIR indicated resident #043 was found on the floor. The resident had sustained an injury, complained of severe discomfort and was transferred to the hospital for further assessment.
The DOC confirmed to Inspector #570 that the CIR was not submitted to the Director within one business day.

The licensee did not notify the Director of the incident involving resident #043 until two business days after the resident's significant change in condition due to the incident. [s. 107. (3)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 3rd day of April, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROLINE TOMPKINS (166), BAIYE OROCK (624), CHANTAL LAFRENIERE (194), DENISE BROWN (626), SAMI JAROUR (570), SARAH GILLIS (623)
Inspection No. / No de l'inspection :	2018_694166_0005
Log No. / No de registre :	001759-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 26, 2018
Licensee / Titulaire de permis :	CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 Valley Farm Road, PICKERING, ON, L1V-3R6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lesreen Thomas

To CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 131 of O. Reg. 79/10
- Ensure that resident #054, #056, #057 and all other residents are administered medications in accordance with the directions for use specified by the prescriber.

- Daily shift audits are completed to prevent medication errors if alternate Medication Administration Records are used.
- Re-education of Registered staff related to Medication Administration practices
- the management company must immediately provide nursing leadership and play an active role in supporting the home in implementing effective response in the analysis of the medication audits, staff education related to medication administration, corrective action as pertains to medication administration practices, including and not limited to medication incidents.

Grounds / Motifs :

1. Licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Review of three high risk medication incidents for the month of August 2017 (discussed at the Professional Advisory Committee Meeting in September 2017) and three high risk medication incidents for the month of January 2018 were inspected by inspector #194.

Review of a medication incident report involving resident #054 indicated RPN #142 did not administered a prescribed medication to resident #054. The medication incident report indicated there was no negative outcome to resident #054 as a result of the medication error.

Review of resident #054's physician's orders indicated the medication was ordered to be administered every 8 hours.
Review of resident #054's Medication Administration Record (MAR) indicated there was no registered nurse signature to indicate that the medication was administered to the resident.

RPN #142 was interviewed by inspector #194 and indicated an unawareness that a medication error involving resident #054 had occurred.

Review of a medication incident report involving resident #057 indicated that an incorrect dosage for a medication ordered by the physician was administered to resident #057. The medication incident report indicated resident #057 did not have negative outcome as a result of the medication error.

Review of a medication incident report involving resident #073 indicated a prescribed medication was not administered to resident #073 for four consecutive days.
RPN,s #108, #143, #144 and #145 were identified as being the staff involved in the medication incident. The medication incident report indicated there was no negative outcome to resident #073 as a result of the incident.

Interview with RPN #108 and RPN #143, indicated RCAM #117 reviewed the 8 rights of medication administration, post medication incident with the registered staff involved.

The severity of this issue was determined to be a level 2 with potential for actual harm. The scope of the issue was a level 2 where a pattern was identified. The home had a level 3 compliance history with non compliance that included:
- Compliance order (CO) issued February 8, 2017, (2016_119626_0032), complied on May 8, 2017
- Voluntary Plan of Correction (VPC) issued August 11, 2017 (2017_643111_0013)

(194)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 01, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

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

Issued on this 26th day of March, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : CAROLINE TOMPKINS

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 8, 2018	2018_694166_0012	006797-18	Follow up

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

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

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 6, 7, 8, 2018

Log #006797-17, follow up to Order #001 related to medication administration was inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with Registered Practical Nurses, Registered Nurses, Resident Care Managers, the Nursing Consultant, the Pharmacist Consultant, the Director Of Care, the Director Of Quality and the Executive Director.

During the course of this inspection, the inspector reviewed the medication administration education program provided to the registered staff, medication incident records, medication administration records and the daily, weekly and monthly audits related to medication administration.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were not issued.
- **0 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (2)	CO #001	2018_694166_0005	166
O.Reg 79/10 s. 53.	WN	2018_694166_0005	166
LTCHA, 2007 S.O. 2007, c.8 s. 6.	WN	2018_694166_0005	166

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.

Issued on this 3rd day of July, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 25, 2018	2018_523461_0019	023618-18	Complaint

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

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

CRISTINA MONTOYA (461)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): An off-site inspection was conducted on August 28, 29, 31, and September 20, 2018

The following intake was completed in this complaint inspection:
Log # 023618-18 related to admission of residents

During the course of the inspection, the inspector(s) spoke with the Executive Director, the acting Director of Care, the Social Worker, the Central East Local Health Integration Network (CELHIN) senior manager, CELHIN placement coordinators, and a Public Health representative.

The following Inspection Protocols were used during this inspection:
Admission and Discharge

During the course of this inspection, Non-Compliances were not issued.
- **0 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

Issued on this 25th day of September, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 27, 2018	2018_694166_0016	021321-18	Complaint

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

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

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 25, 2018

Complaint log #021321-18, related to a fall resulting in an injury to resident #001 was inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with Registered staff, Personal Support Workers and the licensee's Nursing Consultant.

During the course of this inspection, the inspector observed resident #001 and reviewed clinical documentation .

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention

During the course of this inspection, Non-Compliances were not issued.
- **0 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

Issued on this 28th day of September, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 10, 2018	2018_643111_0014	009230-18, 011227-18, 016096-18	Complaint

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 31, 2018

There were three complaints inspected concurrently during this inspection:
-Log # 16096-18 and #011227-18 related to bed refusals.
-Log # 009230-18 related to discharge of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Regional Director for Extendicare Assist and Behavioural Support Ontario (BSO) staff.

During the course of the inspection, the inspector reviewed a discharged resident's health record and reviewed admission packages submitted to the home by CCAC.

The following Inspection Protocols were used during this inspection:
Admission and Discharge

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

The licensee has failed to comply with section 44(7) of the LTCHA whereby the licensee refused the application for applicant #003 for grounds other than provided for in the LTCHA. In addition, the licensee's response to the applicants failed to contain all of the required elements of section 44(9).

Related to log # 026123-17:

This inspection was initiated related to a complaint received by the Ministry of Health and Long Term Care. The complaint pertained to Orchard Villa withholding approval for admission.

A review was completed of applicant #003's admission application and the home's

response letter. The response letter from the Administrator of Orchard Villa indicated on a specified date, applicant #003 was refused a bed due to nursing lacking the expertise to manage the applicants behavioural needs. Review of the admission application indicated there was one incident when the applicant demonstrated specified responsive behaviour. There was no indication the resident demonstrated other responsive behaviours.

An interview with the Administrator by Inspector #111, revealed that the home had a Responsive Behaviour Program (BSO Team) who reviewed the admission applications and would be able to discuss the withholding of approval for admission. The Administrator indicated the approval for admission was withheld due to a concern for specified responsive behaviours by the applicant towards others.

Interview with the BSO team (staff #100 and #101) by Inspector #111, both confirmed the admission application for applicant #003 did not have enough information to support how the nursing staff lacked the expertise to manage specified responsive behaviours. The BSO staff confirmed there was only one incident noted where the applicant demonstrated a specified responsive behaviour.

The licensee had failed to demonstrate grounds for withholding admission to applicant #001. [s. 44. (7)]

2. The licensee has failed to ensure that when withholding approval for admission, the licensee shall gave a written notice setting out the ground or grounds on which the licensee is withholding approval; a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; an explanation of how the supporting facts justify the decision to withhold approval; and contact information for the Director. 2007, c. 8, s. 44 (9).

Related to log # 16096-18:

A record review was completed of applicant #003's admission application and the home's response letter. The letter did not provide a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care, and an explanation of how the supporting facts justify the decision to withhold approval or the contact information for the Director.

During an interview with the Administrator and the BSO team, they acknowledged that

the letter did not include sufficient detail, as required, for withholding an approval of admission to applicant #003.

The licensee failed to ensure that when they withheld an approval for admission, the written notice that set out the explanation, as they related both to the home and to the applicant’s condition and requirements for care, failed to explain how the supporting facts justified the decision to withhold approval.[s.44(9)]

Issued on this 10th day of October, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 3, 2018	2018_643111_0023	029709-18	Complaint

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 8, 2018

A complaint inspection was conducted related to no Registered Nurse (RN) present in the home and a resident death.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Quality Nursing (DQN), Administrative Assistant (AA), Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW).

During the course of the inspection, the inspector also reviewed a deceased resident's health record, reviewed staffing schedules and reviewed the licensee's policy: pronouncing resident death.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

The licensee has failed to ensure that there was at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45.(1) and 45.1 of the regulation).

During an interview with the Administrative Assistant by Inspector #111, indicated awareness of no RN's in the home on at least four occasions and mainly occurred on a specified shift.

During an interview with the Administrator, indicated that he was currently new to the home, the Director of Care was new to the home and was currently away from the home. The Administrator indicated the ADOC is currently off on leave and has been off for a specified period of time.

During an interview with the Director of Quality Nursing, indicated the home had one full time night RN position unfilled for a three month period, when one of the full time Resident Care Assistant's (RCA) filled the position.

Review of the RN staffing schedule for a five month period in 2018 indicated there were 14 identified dates where there were no RNs on-site and working in the home on two different specified shifts.

The licensee failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times. [s. 8. (3)]

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 there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff, on duty and present at all times, to be implemented voluntarily.

Issued on this 5th day of December, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 21, 2019	2019_598570_0005	006538-18, 009314-18, 009543-18, 015513-18, 019959-18, 020274-18, 020491-18, 020992-18, 025112-18, 025677-18, 026997-18, 028500-18, 032391-18	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

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

SAMI JAROUR (570), PATRICIA MATA (571), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): Februrary 19, 20, 21, 22, 25, 26, 27, 28 and March 1, 4, 5, 6, 7, 8, 11, 2019.

During the course of the inspection, the following logs were inspected concurrently:
Log #006538-18, Critical Incident Report related to an allegation of abuse.
Log #009314-18, Critical Incident Report related to a fall resulting in an injury.
Log #009543-18, Critical Incident Report related to a fall resulting in an injury.
Log #015513-18, Critical Incident Report related to a fall resulting in an injury.
Log #019959-18, Critical Incident Report related to an allegation of abuse.
Log #020274-18, Critical Incident Report related to an allegation of abuse.
Log #020491-18, Critical Incident Report related to an allegation of abuse.
Log #020992-18, Critical Incident Report related to an allegation of abuse.
Log #025112-18, Critical Incident Report related to a fall resulting in an injury.
Log #025677-18, Critical Incident Report related to a fall resulting in an injury.
Log #026997-18, Critical Incident Report related to a fall resulting in an injury.
Log #028500-18, Critical Incident Report related to an allegation of abuse.
Log #032391-18, Critical Incident Report related to a fall resulting in an injury.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Residents Care Area Managers (RCAM), Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN), Personal Support Worker(s) (PSW), the RAI Coordinator, Behavioural Support staff (BSO), the Scheduling Clerk, residents and families.

In addition, the inspectors reviewed clinical medical records, the licensee's internal investigations and related policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Related to log #009543-18:

Critical Incident Report was submitted to the Director on an identified date and time. The CIR indicated that on an identified date and time, resident #005 was found on the floor in their room. The resident was sent to hospital for further assessment and was diagnosed with an injury to a body part.

A review of resident #005's current plan of care indicated that the resident was at an identified risk for falls. The plan of care directed that a specified intervention to be applied for falls prevention.

On an identified date and time, Inspector #570 observed resident #005 sitting in their mobility device. Inspector noted the specified intervention was not in place.

During an interview on identified date, Personal Support Worker (PSW) #118 indicated to Inspector #570, that they assisted resident #005 to sit in the mobility device and that the specified intervention was not applied. The PSW indicated no awareness if the resident's plan of care includes the use of specified intervention.

During an interview on identified date, Registered Practical Nurse (RPN) #125 indicated to Inspector #570, that resident #005 was at an identified risk for falls and required the use of a specified intervention. The RPN indicated no awareness that resident did not have the specified intervention in place on specified date. The RPN further indicated that on specified date, a causal PSW staff was assigned to the resident and that the PSW staff should have checked the resident's plan of care and approach registered staff for

directions.

During separate interviews, PSWs #126 and #129 indicated to Inspector #570, that they apply the specified intervention to resident #005 when the resident is transferred out of bed. [s. 6. (7)]

2. A review of resident #005's progress notes for specified date, RPN #125 documented that at specified time the resident was found sitting on the floor in bathroom. The resident had been given routine toileting and was left unattended while the staff attended to another resident. RPN #125 documented that staff was to always remain with resident as the resident should not be left alone during toileting.

A review of resident #005's plan of care, indicated that resident #005 self-transfers and had falls related to toileting. The plan of care directed not to leave resident alone in the bathroom.

During separate interviews, PSW #130 and #131 indicated to Inspector #570, that on an identified date and time, they transferred resident #005 to the toilet. PSW #130 and #131 further indicated that they left resident #005 on the toilet unattended to attend to another resident.

During an interview, RPN #125 indicated to Inspector #570, that resident #005 was found sitting on the floor in front of the toilet. The RPN indicated that staff should have stayed with the resident when being toileted as directed in the plan of care. The RPN confirmed that the resident's plan of care was not followed.

During an interview, the Director of Care (DOC) indicated to Inspector #570, that the incident on an identified date was investigated and determined that staff did not follow the plan of care for the resident. The DOC indicated that it is an expectation that staff should follow resident's plan of care at all times.

The licensee did not ensure that care was provided to resident #005 as directed in the plan of care. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the preliminary report made to the Director within 10 days, was followed by a final report within the time specified by the Director (in 21 days unless otherwise specified by the Director).

Related to Log # 019959-18:

Critical Incident Report (CIR) was submitted to the Director on an identified date, for an allegation of resident to resident abuse. The CIR indicated the incident occurred on an identified date time when resident #016 reported that resident #015 caused an injury to a body part.

During an interview, the Director of Care (DOC) confirmed to Inspector #570 that a final report was not provided to the Director in a timely manner due to a change in management at the home.

The final report to the Director was not submitted indicating the outcome of the licensee's investigation until an identified date (greater than 21 days). [s. 104. (3)]

Issued on this 25th day of March, 2019

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

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 11, 2019	2019_670571_0003	005232-18, 008750-18, 019941-18, 021207-18, 032775-18, 032818-18, 000450-19, 001033-19, 005707-19	Complaint

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

PATRICIA MATA (571), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 19-22, 25-March 1, March 4-8, 2019

The following complaint intake logs were inspected:
005232-18; 008750-18; 032775-18; 032818-18 related to resident care
019941-18 related to personal care, maintenance and supplies
021207-18 related to supplies and staffing
000450-19 related to resident abuse
001033-19 related to safe lift and transfers
005707-19 related to resident change in condition

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Resident Care Area Managers (RCAM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Services Supervisor (ESS), Housekeeper and Laundry Aides.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that assessments are integrated, consistent with and complement each other.

Related to a complaint:

A complaint was received by the Director from the Action Line, on a specified date. The complainant alleged resident #010 had been neglected. The SDM voiced concerns to the nursing staff about a change in condition for resident #010, and requested a specified intervention. The complainant indicated that the requested specified intervention was not done for a specified time period.

A review of the resident's clinical medical records by Inspector #571 indicated that resident #010 had a history of a specific medical condition.

A review of the physician orders by Inspector #571 for a specified period indicated the following:
-on a specified date: Physician ordered an identified medical intervention; a number of days later the Nurse Practitioner (NP) re-ordered the intervention as the original order had not been implemented and on the same day the Physician ordered a specified medication; a number of days later, the Physician ordered additional medication to treat the identified medical condition; a number of days later, the Physician ordered that the resident be transferred to the hospital.

A review of the progress notes indicated that the Physician was not contacted for a number of days after the SDM brought their concerns forward to RPN #133. The initial

Physician's order was not carried out until a number of days later when the Physician had to rewrite the order. The resident's condition continued to deteriorate.

In separate interviews with Inspector #571, RPN #122, #123 and #137 indicated that they could not recall the events related to this complaint.

RPN #122 indicated that their normal practice would be to make a note in the Physician's book if a family requested an order be obtained. If the matter was urgent they would call the Physician during the day or the on-call Physician after hours. If an order was not implemented on their shift, RPN #122 would report it to the oncoming nurse verbally and write it in the 24 hour unit report.

RPN #123 indicated that their normal practice would be to make a note in the Physician's book if a family requested an order be obtained if the Physician was coming in to the home within the next few days. If the matter was urgent they would call the Physician during the day or the on-call Physician after hours or the NP. RPN #123 indicated that if they were unable to implement the order, they would call the Physician or NP. RPN #123 was asked by Inspector #571 how many days they would they try to implement an order before they called the Physician and they indicated that if the resident was symptomatic they would call right away. The RPN indicated that if an order needed to be implemented and was not completed on their shift, then it would be communicated to the next shift using the nurses 24 hour unit report or in the progress notes or verbally during shift report. The RPN indicate that their practice was to read the progress notes from the previous shift.

RPN #137 indicated that if a family member requested an order be obtained from the Physician, they would assess the resident and call the Physician if the matter was urgent. If the matter was not urgent they would write it in the Physician communication book and document a progress note so that staff would continue to monitor and call the Physician if there are any change in condition for the resident. If the Physician was not coming in for a number of days the RPN would either call the Physician or ask another Physician who is in the building to see the resident. RPN #137 indicated that if they were unable to implement a Physician order they might try for a number of days but if the resident's condition was deteriorating than they would call the Physician to inform them. RPN #137 indicated the need for an order to be implemented if not done on their shift was to be communicated by writing it in the 24 hour unit report and the progress notes and via the verbal shift report. RPN #137 may also inform the charge RN. The RPN indicated that when they come on shift they would normally receive verbal report from the nurse on the

previous shift and read the 24 hour unit report where the previous nurse had given a summary of significant points. They would also run the report from Point Click Care (PCC) for the last 24hrs. In addition, the chart would remain flagged on the cart if the order has not been implemented because the nurse is not supposed to sign the Physician's order as processed until the order was implemented. The flagged charts are normally kept on their side in the cart and the charts without orders that do not need to be checked are kept in an upright position on the cart. RPN #137 indicated that they check the charts that are flagged every shift but sometimes the chart is backwards or the flag is accidentally pushed back in so they may not see the flag and they do not always check those charts for unprocessed orders. When asked by Inspector #571 if there was any other way a nurse would know that a Physician order still needed to be implemented, the RPN described a different specific intervention that is utilized so that the nurses would know the order had not been implemented yet.

The concerns brought forward to the nursing staff by the SDM for resident #010 were not communicated to the Physician by the nursing staff in a timely matter when the resident's condition deteriorated. When a specific order was received, there was no indication this had been communicated between the shifts, and when the order was not implemented there was no indication that there was collaboration from shift to shift. There was no indication that nursing staff communicated with the Physician, to inform them that the order had not been implemented despite the resident's condition deteriorating. A number of days after the Physician ordered a specified medical intervention it had not been implemented. Although resident #010 was treated starting a number of days after the SDM first voiced their concern to the registered nursing staff and a number of days after the Physician originally wrote the order, the resident required transfer to the hospital.

The licensee failed to ensure that staff and others involved in the different aspects of care for resident #010 collaborate with each other in the assessment of the resident so that assessments are integrated, consistent with and complement each other. [s. 6. (4) (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 with ensuring that staff and others involved in the different aspects of resident care collaborate with each other in the assessment of the resident so that assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Related to a complaint:

A complaint was submitted to the Director on a specified date that included a concern about staff completing improper transfers.

On a specified date, Inspector #571 observed resident #003 in the hallway. Inspector #571 observed PSW #106 assist resident #003 into their room. Shortly afterwards, PSW #106 exited resident #003's room alone. Inspector #571 immediately observed the resident lying in bed.

A review of resident #003's current care plan indicated that the resident required two staff for transfers.

In an interview with Inspector #571, PSW #106 acknowledged that they transferred resident #003 to bed by themselves. PSW #106 indicated that they knew the resident required two staff for transfers but that they were trained by co-workers to transfer the resident with one person. PSW #106 indicated that the plan of care instructs that the

resident was to be transferred with two staff.

In an interview with Inspector #571 on February 28, 2019, the DOC indicated that it was their expectation that two staff transfer resident #003 as per the resident's plan of care.

Therefore, the licensee has failed to ensure that staff use safe transferring techniques when transferring resident # 003. [s. 36.]

2. Related to a Critical Incident:

A Critical Incident (CI) was submitted to the Director for an incident occurring on a specified date. The critical incident indicated that PSW #113 was transferring resident #007 when the resident slid to the floor.

A review of the licensee's policy LP-01-01-02 Last Updated August 2017 included the following: "Two trained staff are required at all times when performing" a specified lifting technique. "All breaches of the policy or procedure will result in an investigation, and may result in progressive discipline up to and including terminations."

In an interview with Inspector #571, PSW #113 indicated that they did transfer the resident by themselves. PSW #113 acknowledged that the policy indicates that two staff members are to be present when using the specified transfer technique.

In an interview with Inspector #571 on February 28, 2019, the DOC indicated that their expectation is that two staff were to be present when the specified transfer technique was used for resident transfers. This incident was investigated and action taken.

Therefore, the licensee has failed to ensure that staff use safe transferring techniques when transferring resident #007. [s. 36.]

3. Related to Resident #014:

A review of the licensee's investigation notes for an incident related to a separate log involving resident #014 indicated that PSW #145 had used an improper transfer technique to transfer the resident on a specified date.

In an interview with Inspector 571, PSW #145 indicated that they did not use the transfer technique as specified in the resident's plan of care.

A review of the "Safe Lift and Transfer Assessment - V2" from a specified date, indicated that a specified transfer technique was to be used for resident #014 and that a transfer logo was displayed for staff reference.

Therefore, the licensee has failed to ensure that staff use safe transferring techniques when transferring resident #014. [s. 36.]

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 for ensuring that staff use safe transferring techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, there is a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by the residents.

Related to three complaint logs.

Complaint:
An anonymous complaint was received on a specified date, via the Action Line indicating that there are not enough towels to provide care to the residents and not enough linens to change the beds. The complainant indicated that laundry is getting done, there is just

not enough to go around.

Complaint:
An anonymous complaint was received via the Action Line on a specified, indicating that the home is in short supply of soaker pads, sheets and bath towels. The complainant indicated that this issue has been brought to the attention of the home's Administrator, but the issue has not been resolved. The management team was aware of the issue.

Complaint:
An anonymous complaint was received on a specified date, by the Action line, indicating that the home does not have enough linens for all of the units and that the home is no longer using soaker pads.

Observation in the home by Inspector #623 on a specified date identified the following:

On an identified resident home area- all resident beds were made and there was a complete change of linen. Most bathrooms did not have face cloths or towels hanging on the towel rack. 10 beds had clean face cloths and towels folded on beds that were made. Each linen cart had approximately 10 face cloths, two towels and two sets of sheets. The linen cupboard was locked at the time and staff were not available to unlock the cupboard. In the tub room there was a bin with incontinent products of all sizes.

On an identified resident home area- all but one resident beds were made with a complete change of linens. The one bed was stripped to the mattress. There were no face cloths or towels in any of the resident's bathrooms. There were six resident rooms with clean face cloths and towels folded on the bed. The linen cart had two sets of sheets available, five face cloths and one towel. The Spa room had no bath towels, but there were 10 face cloths, five hand towels and four sheets. There was a large Rubbermaid bin on the floor that was filled with a variety of continence products.

On an identified resident home area- all resident beds were made and there was a complete change of linen. Most resident bathrooms did not have face cloths or towels in them. Six resident rooms had clean towels and face cloths folded on the bed. The linen carts did not have any sheets, each had four face cloths and no hand towels. The Spa room was occupied.

On an identified resident home area- there were two residents beds not made (unclear if they were vacant beds, no names identified on the door). All other beds were made and

there was a complete change of linen. One linen cart was located in entry to a resident's room. The cart had no sheets, two face cloths and no towels. There were no towels located in the resident bathrooms. Four resident rooms had a folded face cloth and towel on their bed. The Spa room did not have any bath towels. There was a bin with a variety of continence products available.

Review of the Inventory count sheet – Bedding, linen and towel - for an identified period, indicated the following linens were available in the home for 233 residents:
Wash cloths – 580
Hand towel – 448
Bath towel – 54
Flat sheet – 220
Fitted sheet – 240

A second inventory count sheet – Housekeeping supplies – for an identified area, indicated the following linens were available in the home for 233 residents:
Towels and Face cloths – 580
Bath towel – 54
Hand towel – 72
Face cloths – 120
Peri cloths – 0
Fitted sheets – 36
Flat sheets – 42

Review of the Extendicare Policy HKLD 06-01-01 Appendix 2 indicated the following:

Extendicare has recommended linen inventory standards that take into account a 2.5 day supply of quotas. (Orchard Villa has 233 residents)

Recommended guidelines:
Top Sheets – 2.0 per bed
Bottom Sheets – 2.0 per bed
Face Cloth (personal care) – 4.5 per bed
Hand Towel (personal care) – 4.5 per bed
Bath Towel – 2-3 per scheduled bath per day x 2.5 days' supply

On two specified dates, Inspector #623 completed a tour of all resident homes areas to observe linen supplies. All beds were made and there was a complete change of linen.

The linen carts had a small supply of linens available. There were bath towels present in all spa rooms. The resident's bathrooms had a hand towel and a face cloth on the towel bar in each bathroom. There was no shortage of linens identified.

On a specified date, Inspector #623 completed observations on an identified resident home area home area that revealed there were four beds stripped to the mattress and there was no linen available to make the beds. No towels or facecloths in any resident rooms. There were no towels in the Spa room. The linen cupboard contained bedspreads, blankets, and one flat sheet.

Review of the Extendicare Policy HKLD 06-01-01 Appendix 2 indicated the following:

Extendicare has recommended linen inventory standards that take into account a 2.5 day supply of quotas. (Orchard Villa has 233 residents)

Recommended guidelines:
Top Sheets – 2.0 per bed
Bottom Sheets – 2.0 per bed
Face Cloth (personal care) – 4.5 per bed
Hand Towel (personal care) – 4.5 per bed
Bath Towel – 2-3 per scheduled bath per day x 2.5 days' supply

On a specified date, during an interview with Inspector #623, PSW #103 indicated that on most days they are short linens and continent supplies including incontinent products and wipes. The PSW indicated that this week, there has been more than enough supplies of everything. The PSW indicated that if they run out of continence supplies on the unit, they can get more but have to request it from the RN supervisor. The PSW indicated that if there is a staff shortage in the laundry department than there is no linen in the morning. The day linen person arrives and would have to wash and dry the quota for the units. This could take until about 10 am before supplies are available. The PSW indicated that this happens one to two times a week. If there is a shortage of towels, then residents might not get washed properly for morning care and showers will not be given. The PSW indicated that when the cart does arrive in the unit, they try to find enough linen to get their work done. The PSW indicated that they report shortages to management but nothing seems to happen about it.

On a specified date, during an interview with Inspector #623, PSW #111 indicated that there was an adequate supply of linens and towels that day. They also indicated that

they have access to continence supplies including wipes, and that they do not run out of continence supplies. The PSW indicated that they might need to ask the RN for more, but they are always available.

On a specified date, during an interview with Inspector #623, PSW #137 indicated four beds were unmade because there were no linens available this morning. PSW #137 indicated that there was a staff shortage in laundry and at 0700 hours, there were no linens for the day shifts. The PSW indicated that they did not have face cloths, hand towels, bath towels, or sheets. The PSW indicated that the DOC provided them with wet and dry wipes so that morning care could be completed and at 1000 hours, the laundry was able to provide six bath towels for each unit so that residents could receive their bath. There were nine residents scheduled to receive a bath or shower that day. A small quantity of face cloths, hand towels and sheets were also provided to the units so that some of the resident's beds could be made. The PSW indicated that not every resident required linens to be changed daily. The PSW indicated that this happens often, where they are short of linen supplies, but could not recall when the last time was. The PSW indicated that if baths cannot be completed because they do not have enough towels, then they must report this to the RPN so that they can pass this information on to Management. The RPN indicated that baths are supposed to be made up the following shift or the following day, but someone else is scheduled to complete this task.

On a specified date, during an interview with Inspector #623, RPN #144 indicated that this morning they were short linens and towels. The RPN indicated that when the day shift started, there was no linen cart available for the an identified resident home area. The RPN indicated that they were informed there was a staff shortage in laundry, therefore the laundry did not get washed and would not be available until the day laundry aide could get it washed and dried. The RPN indicated that this happens frequently. RPN #144 indicated that today and on another identified morning, the DOC provided wet and dry wipes so that the resident's morning care could be provided. The RPN indicated that any residents who were scheduled for a bath or shower would have to wait until the towels were available. The RPN indicated that if a resident does not receive a bath because there were not enough towels, then the DOC must be informed so that the bath could be rescheduled. The RPN indicated that they are also expected to document that the bath was missed and notify the SDM.

On a specified date, during an interview with Inspector #623, Laundry Aide (LA) #141 indicated that they worked on the day shift. The night shift is responsible for washing all the towels, sheets and face cloths, so that they are ready for the morning. The laundry

aide indicated that when they arrive on shift, they are responsible to deliver the clean linens to the resident home areas units. LA #141 indicated that morning there were no linens and towels washed and ready for delivery because they were short staffed on a previous shift. LA #141 indicated that this happens often, and when it does, the nursing staff do not have the supplies they need for morning care. The LA indicated that if a laundry staff were to call in sick after hours, there is no one there to take the call and cover the shift.

On a specified date, during an interview with Inspector #623, Housekeeper #142 indicated that when they are behind in the laundry the housekeeper is pulled from their job to help fold laundry so that it can be delivered to the resident home areas. The housekeeper indicated that this happens every couple of weeks, but this week it had happened two times. The housekeeper indicated that when they are asked to assist with the laundry, there is no one completing their housekeeping work.

On a specified date, during an interview with Inspector #623, the DOC indicated that the Environmental Services Supervisor (ESS) and the Programs Manager are collaboratively overseeing the Environmental Services in the home while there is a vacancy for the Environmental Services Manager (ESM) role. The DOC indicated that there was an issue that day with staffing shortage in the laundry and there was also an issue on another identified day. The DOC indicated that they have discussed with the ED the impact this has on nursing and the need for a staffing back up plan for laundry when the night shift calls in sick. The DOC indicated that today and also another date, the PSW staff did not have towels, facecloths, and bath towels for morning care because there was no none in laundry to wash the supplies and deliver them to the units for morning due to staff shortage. The DOC indicated that this has happened twice that week, but had happened at least once every three weeks. The DOC indicated that that morning and on another specified date they distributed wet wipes and dry wipes so that morning care could be provided to the resident's. The DOC indicated that on a specified date all showers and baths were given, the DOC would be monitoring to ensure that all showers and baths were given and if necessary, they would schedule a PSW to make up the baths if any were missed.

On a specified date, during an interview with Inspector #623, the ESS indicated that at this time they are assisting with the management of Environmental Services, in the absences of a manager. The ESS indicated that together with the Resident Program Manager, they cover the department. The ESS indicated that they were short staff that day. The ESS indicated that when the laundry staff call in sick, they call and leave a

message. If it is after hours, no one will get that message until the next day. This is what happened the previous evening causing the laundry to be incomplete for morning. The ESS indicated that the LA who works on the night shift was responsible for washing all of the towels, face cloths, hand towels and sheets so that they were clean and ready to be delivered to the units early in the morning. When this shift is left unfilled, it causes a backlog in the laundry. There is no emergency or pandemic supply of linens to draw from. The ESS indicated that have an ongoing problem with staff shortages. The ESS indicated that there is no extra linens, towel or face cloths, laundry was done just in time, and there was no buffer for when the system failed. The ESS indicated that they believe that there was enough linens, but staff were hoarding them so it appeared that they were short. The ESS indicated that together with the Executive Director (ED), they were working on a plan going forward so this does not happen again.

During an interview with Inspector #623, the ED indicated that they were aware that when there was a staff shortage in the laundry department, this left a gap in the delivery of supplies to the resident home areas. The ED indicated in an identified time period , staff had complained about the shortage of laundry supplies, and the Regional Director (RD) was looking into the available supplies with the former ESM. The ED indicated that there was an email inquiry by the RD to the ESM. At that time the RD asked if there was enough linen for a 24 hour supply. The RD also requested a count of the linen supplies. The response from the ESM was that they depend on the laundry processing to keep up the supply and that they believed there was more than 24 hours' worth of linen in the cycle each day. The ESM indicated that they release additional supplies weekly to compensate for shortages and have increased the supplies in the recent months. The ESM also indicated in the email that they would provide a projected daily linen requirement as they move towards a 24 hour cart system and identified that they would need to ramp up inventory to three times the quantity in order to compensate for this. The ED indicated that at the end of a specified time period, they provided the RD with the total linen inventory count. The ED indicated that they were uncertain of what the number on the count sheets represented or why there were two different lists. The ED did not know if the two lists should be added together to create the final count of available linens in the home. The ED indicated that they were unable to provide any further information regarding the outcome of the RD's inquiry related to the linen supply. The ED indicated that there was a gap in the call in process to cover unexpected absences in the laundry department. The ED indicated that it appears by looking at the inventory count sheets, that they do not have the required amount of linens for the home, as indicated in the Extendicare Policy HKLD 06-01-01 Appendix 2 – Linen Inventory Standards Guidelines (September 2013). The ED indicated that the inventory count sheets were completed by

the former ESM and were submitted to Head Office for the end of the year. The ED was also not aware of any additional linen supplies in storage that could be put into circulation at this time. The ED indicated that they are currently in discussions with head office, to move to a 24-hour delivery cart system for linens but this has not been implemented yet.

The licensee failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, there is a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by the residents. [s. 89. (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 for ensuring that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, there is a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by the residents., to be implemented voluntarily.

Issued on this 29th day of April, 2019

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

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419, rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 24, 25, 2019	2019_670571_0011	010700-19	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

PATRICIA MATA (571)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 3, 4 and 5, 2019

Log #010700-19 related to an incident that causes an injury for which the resident is taken to the hospital.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Physician, Registered Nurses, Registered Practical Nurses and Personal Support Workers.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that RPN #101 collaborated with physician #104 when the RPN suspected that resident #001 sustained an injury.

Log #010700-19:

A CIR was submitted for an incident that occurred that resulted in a fall and injury of resident #001. On a specified date and time, resident #001 sustained an injury while care was being provided by PSW #100.

A review of the progress notes for resident #001 indicated that on a specified date and time, resident #001 fell and sustained an injury and was experiencing pain to two specified areas. Medication was administered for pain. Two hours after the resident fell, RN Supervisor #102 documented they that were called to assess the resident. The resident displayed an identified symptom from the injury and complained of severe pain to an identified area of their body. RN Supervisor #102 instructed RPN #101 to inform the Substitute Decision Maker (SDM) and see if the SDM wanted resident #001 sent to the hospital for further treatment and evaluation. Approximately three- and one-half hours after the incident, RPN #101 documented that resident one was exhibiting an identified symptom and severe pain was also noted. The resident displayed physical evidence of pain and was verbalizing that they were in pain. The SDM was informed of the fall and assessment of the resident. The SDM instructed that they wanted the physician to assess the resident in the home in the morning. Approximately five hours after the incident occurred, on the next shift, RN Supervisor #103 documented that the resident

was experiencing pain during personal care. The resident exhibited clear signs of injury to an identified area of their body. The SDM was called and the resident was transferred to the hospital.

On a specified date, the resident was admitted to the hospital with an identified diagnosis.

In an interview with Inspector #571, the DOC indicated that the resident was not transferred to the hospital immediately. Resident #001 was transferred to the hospital on the next shift when the RN came in and assessed the resident for complaint of pain and observed symptoms of injury. The physician was not informed of the fall and pain until the following day after the resident was transferred to hospital.

In an interview with Inspector #571, RPN #101 indicated that they suspected the resident had sustained an identified injury and were trying to manage the resident's discomfort. They did not call the physician; they were going to observe the resident and have the physician see the resident the following morning. RPN #101 gave the resident medication for pain after the incident. They indicated that the resident had felt more comfortable after the administration of the medication.

In an interview with Inspector #571, RN #102 indicated that the RPN would normally complete the assessment after the identified incident. The RN came to the unit where resident #001 resided. The RN asked RPN #101 about the resident's condition and instructed RPN #101 to call the SDM to inform them of the incident. RN #102 indicated that RPN #101 should have informed the physician.

In an interview with Inspector #571, physician #104 indicated that if a staff member suspected an identified injury, they should send the resident to the hospital or call the physician to discuss. If the SDM doesn't wish the resident to go to the hospital, then the SDM's wishes take precedence over the physician. The physician was made aware of the incident the morning following the incident.

The licensee failed to ensure that RPN #101 collaborated with the physician, after the SDM decided that the resident should wait to be seen by physician in the morning. The RPN suspected that resident #001 sustained an identified injury after the fall when the resident exhibited an identified symptom and complained of severe pain but the physician was not notified until the following morning after the resident was transferred to hospital. [s. 6. (4) (a)]

2. The licensee has failed to ensure that resident #001 was provided care as specified in the plan of care.

Log #010700-19:

A CIR was submitted for an incident. On an identified date and time, resident #001 fell and sustained an injury while care was being provided by PSW #100.

A review of the care plan in place on the day of the incident for resident #001 indicated that the resident required two staff to provide an identified care need.

A review of the progress notes related to the incident on the specified date indicated that resident #001 sustained an injury during the provision of care. The resident required hospitalization for an identified diagnosis related to injury from the incident.

In an interview with Inspector #571, the DOC indicated that as per resident #001's care plan, two staff were to provide care to the resident. PSW #100 was aware two staff were to be present during care.

In an interview, PSW #100 indicated that on the identified date, they were providing care to resident #001. An identified incident occurred during the provision of care. PSW #100 acknowledge that they knew the resident required two staff for the identified area of care. PSW #100 had provided the identified area of care alone to the resident in the past. PSW #100 explained that the care plans for the residents were available and accessible.

The licensee failed to ensure that PSW #100 provided care to resident #001 as specified in the plan of care. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that Registered Staff collaborate with the physician when a fracture is suspected after a fall, to be implemented voluntarily.

WN #2: 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 Regulation required the licensee of a long-term care home to have, institute or otherwise put in place a policy, that the policy was complied with.

Log #010700-19:

A CIR was submitted for an incident. On an identified date, resident #001 sustained an injury while care was being provided by PSW #100.

In accordance with O. Reg 79/10, s.48 (1) every licensee of a long-term care home shall ensure that 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury is developed and implemented in the home.

Specifically, staff did not comply with the licensee's "Falls Prevention and Management

Program" policy #RC-15-01-01 last revised February 2017. Appendix nine "Post Fall Clinical Pathway" of the policy indicates that after a resident has a fall, a focused assessment by the first Registered staff person on the scene is completed and a clinical decision by the Registered staff is made whether the resident will be moved.

A review of the progress notes for resident #001 indicated that on a specified date, the resident experienced a fall.

A review of the licensee's investigation notes indicated that in their interview with PSW #100, the PSW informed the Director of Care that they transferred resident #001 from the floor to the bed after the fall and provided care to the resident before a Registered staff member had assessed the resident for injury.

In an interview Inspector #571, the DOC indicated that PSW #100 transferred resident #001 back to bed after a fall and proceeded to provide care after calling PSW #105 to help. One PSW transferred the resident back to bed and two PSWs provided care before a registered staff assessed the resident.

In an interview with Inspector #571, PSW #100 indicated that on a specified date, they were providing care to resident #001 and during the care, the resident fell out of bed. PSW #100 proceeded to return the resident to bed using a mechanical lift and continued to provide care to the resident before a registered staff member had assessed the resident for injury. PSW #100 indicated that they knew they were not to move the resident until a registered staff assessed the resident.

The licensee failed to ensure PSW #100 complied with their Fall Prevention and Management Program policy. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring a Registered staff member assesses all residents after a fall before they are moved, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that PSW #100 used safe transferring techniques when assisting resident #001.

Log #010700-19:

A CIR was submitted for an incident on identified date.

A review of the licensee's policy LP-01-01-02 titled "Mechanical Lifts" Last Updated August 2017 included the following: "Two trained staff are required at all times when performing a Mechanical Lift. All breaches of the Mechanical Lift policy or procedure will result in an investigation and may result in progressive discipline up to and including terminations."

A review of the licensee's investigation notes indicated that in an interview with PSW #100, the PSW informed the Director of Care that they transferred resident #001 using a mechanical lift. PSW #100 did not have the assistance of a second staff member.

In an interview with Inspector #571, the DOC indicated that PSW #100 transferred resident #001 without assistance using a mechanical lift and was aware that two staff were required.

In an interview with Inspector #571, PSW #100 indicated that on a specified date, when they were providing care to resident #001 they transferred the resident using the mechanical lift without the presence of a second staff member. PSW #100 acknowledged that they knew the resident required two staff for transfers.

The licensee failed to ensure that PSW #100 used safe transferring techniques. [s. 36.]

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 by ensuring staff use safe transferring techniques, to be implemented voluntarily.

Issued on this 31st day of July, 2019

[redacted]

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	PATRICIA MATA (571)
Inspection No. / No de l’inspection :	2019_670571_0011
Log No. / No de registre :	010700-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 24, 25, 2019
Licensee / Titulaire de permis :	CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.) 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 Valley Farm Road, PICKERING, ON, L1V-3R6
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Lesreen Thomas

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

To CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s.6 (7) of the LTCHA.

Specifically, the licensee must:

1) Ensure Personal Support Workers (PSW), are made aware that they must follow the plan of care for residents, related to the number of staff members required for personal care, by providing education and a documented record must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was provided care as specified in the plan of care.

Log #010700-19:

A CIR was submitted for an incident. On an identified date and time, resident #001 fell and sustained an injury while care was being provided by PSW #100.

A review of the care plan in place on the day of the incident for resident #001 indicated that the resident required two staff to provide an identified care need.

A review of the progress notes related to the incident on the specified date indicated that resident #001 sustained an injury during the provision of care. The resident required hospitalization for an identified diagnosis related to injury from the incident.

In an interview with Inspector #571, the DOC indicated that as per resident

#001's care plan, two staff were to provide care to the resident. PSW #100 was aware two staff were to be present during care.

In an interview, PSW #100 indicated that on the identified date, they were providing care to resident #001. An identified incident occurred during the provision of care. PSW #100 acknowledge that they knew the resident required two staff for the identified area of care. PSW #100 had provided the identified area of care alone to the resident in the past. PSW #100 explained that the care plans for the residents were available and accessible.

The licensee failed to ensure that PSW #100 provided care to resident #001 as specified in the plan of care.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #001. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 3 history as they had on-going non-compliance with this section of the LTCHA and three or fewer compliance orders that included:
- compliance order (CO) issued on September 8, 2016 (2016_327570_0014) with a compliance date of October 31, 2016
- written notification (WN) issued on November 25, 2016 (2016_327570_0022)
- written notification (WN) issued on March 9, 2017 (2017_360111_0001)
- Director's referral (DR) with CO issued on November 8, 2017 (2017_643111_0013) with a compliance due date of November 15, 2017
- voluntary plan of correction (VPC) issued on March 21, 2019 (2019_598570_0005)

(571)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 24th day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Patricia Mata

Service Area Office /
Bureau régional de services : Central East Service Area Office

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 6, 2019	2019_655679_0028	006153-19, 006582-19, 010255-19, 015530-19, 017919-19, 020201-19	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MICHELLE BERARDI (679), DAVID SCHAEFER (757), KEARA CRONIN (759), LAUREN TENHUNEN (196), MELISSA HAMILTON (693), STEVEN NACCARATO (744)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 4-8, 2019.

The following intakes were inspected upon during this Critical Incident System (CIS) Inspection:

- Five intakes submitted to the Director for resident falls; and,

- One intake submitted to the Director for alleged staff to resident abuse.

PLEASE NOTE: A Compliance Order (CO) related to s. 6. (7) of the Long-Term Care Home's Act, 2007, was identified in this inspection and has been issued in Inspection Report #2019_655679_0030, which was conducted concurrently with this inspection.

A Complaint Inspection (2019_655679_0029) and a Follow Up Inspection (2019_655679_0030) were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Acting Assistant Director of Care (AADOC), Registered Nurse (RN) Supervisor, Restorative Care Registered Practical Nurse (RPN), RNs, RPNs, Resident Assessment Instrument (RAI) Coordinator Backup, Housekeeping Aides, Personal Support Workers (PSWs), residents and families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, complaint records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003, #004, #005, and #011 have been protected from abuse by anyone.

A Critical Incident (CI) report was submitted to the Director on a specified date, indicating that there were separate incidents of alleged staff to resident abuse.

A) Inspector #759 reviewed the CI report that was submitted to the Director. It indicated that RPN #103 witnessed PSW #102 allegedly abusing residents #003, #004 and #005 on separate occasions.

During an interview with PSW #104, they indicated that if they witnessed or were informed of an incident that would be considered abuse, they would report it to their supervisor or the nurse in charge.

Inspectors #759 and #679 interviewed RPN #103, who indicated that if they witnessed anything worrisome it was their duty to report to their supervisor or the Director Of Care (DOC). RPN #103 confirmed that they witnessed the incidents between PSW #102 and residents #003, #004, and #005. When asked by Inspector #759 if they reported these incidents immediately, they indicated that they reported the last two incidents right away and had not reported the first incident immediately. RPN #103 indicated that they were disciplined for not reporting and completed additional education.

Inspector #759 reviewed a specified document which outlined an interview between the previous Director of Clinical Care #123 and RPN #103. When RPN #103 was asked by the previous Director of Clinical Care #123 why they had not reported the allegations at the time of the incidents, the RPN #103 stated a specified reason.

Inspector #759 reviewed the policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting RC-02-01-01" last revised June 2019. It indicated that "anyone who witnesses or suspects abuse or neglect of a resident by another resident, staff, or other person must report the incident. At minimum, any individual who witnesses or suspects abuse or neglect of a resident must notify management immediately".

During an interview with Inspectors #759 and #679, the DOC indicated that they expected staff to report any suspected or actual abuse immediately to their supervisors, the DOC, or the Administrator. The DOC further indicated that based on the training that RPN #103 had received they should have reported the incidents immediately.

During an interview with the Administrator, they identified that they recalled this CI report, as there were separate incidents reported at once. The Administrator further indicated that they would have expected RPN #103 to report the incidents immediately.

B) During an interview with RPN #103, they revealed additional incidents of potential staff to resident abuse. RPN #103 further indicated that they had not reported the incident that occurred with resident #011 for a specified reason.

During an interview with the DOC, they indicated that based on the training and retraining of RPN #103, that both incidents referenced above should have been reported immediately to the supervisor. The DOC also indicated that they would submit a CI report and follow up with RPN #103.

On November 12, 2019, Inspector #759 reviewed the Ministry of Long-Term Care's online reporting portal and did not identify any CI reports relating to the above noted incidents.

C) Inspector #759 reviewed the policy titled "Zero Tolerance of Resident Abuse and Neglect Program RC-02-01-01" last updated June 2019. It indicated that "any form of abuse or neglect by any person will not be tolerated" and that "there is a zero tolerance for abuse".

Inspector #759 reviewed a specified document. The document indicated that RPN #103 was in violation of the following policies: Zero Tolerance for Abuse and Neglect, Failure to Report Immediately, Commitment to Resident-Centered Care and Resident's Bill of Rights.

Inspector #759 reviewed a specified document. The document indicated that PSW #102 was in violation of the following policies: Zero Tolerance for Abuse and Neglect, Commitment to Resident-Centered Care, Resident's Bill of Rights.

During an interview with the DOC, they indicated that they believed these incidents occurred as it was reported, and one resident was able to identify PSW #102.

The licensee has failed to ensure that residents #003, #004, #005, and #011, had been protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A CI report was submitted to the Director on a specified date, related to a fall of resident #006 which resulted in an injury.

A review of resident #006's most recent Minimum Data Set (MDS) assessment indicated that the resident required a specific level of mobility assistance from staff.

Inspector #744 reviewed resident #006's current care plan which indicated that the resident required a different level of mobility assistance from staff.

In an interview with Inspector #744, RN #122 indicated that resident #006 currently required a specified level of assistance from staff. RN #122 further stated that the care plan was unclear and had not represented the resident's current mobility status.

Inspector #744 interviewed the DOC who stated that they had confirmed the current mobility status with resident #006's RN and that the appropriate changes would be made to make the care plan more clear. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #007's plan of care was reviewed and revised when the resident's care needs changed.

The home submitted a CI report to the Director, which stated that resident #007 had a fall on a specified date. The report indicated that the resident had a number falls over a specified period.

A review of resident #007's electronic fall risk screening tool, indicated that the resident was at a specific level of risk for falls. The tool also indicated specified risk factors for falls.

A review of resident #007's care plan, at the time of the resident's fall, indicated a focus and goals related to falls. The care plan included two specific interventions to mitigate the risk of falls.

During an interview with RN #116, they reviewed the fall risk screening record for resident #007 and stated, "what would have minimized [their] risk [were] the things that [were] in place now" and "things should have been in place prior to that", referring to the resident's fall on a specified date. The RN noted that based on this fall risk assessment, falls prevention interventions should have been in place. The RN noted that the care plan

dated a specified date, in place at the time of the resident's fall, indicated that the resident was ambulating with a specified intervention, which was not current at the time of the fall. The RN added that the home's post-fall assessment which stated to "review and update care plan", was not followed.

During an interview with the DOC, they indicated that based on the electronic fall risk screening record for resident #007, they would expect that the resident would be reassessed, and changes would be made to the plan of care. The DOC stated that the home's falls lead was expected to assess residents when they have a fall and make sure that the care plan was updated. The DOC confirmed that the care plan was not reviewed and updated to put falls prevention interventions in place. [s. 6. (10) (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 ensuring that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and that resident's plans of care are reviewed and revised when the residents care needs change, to be implemented voluntarily.

WN #3: 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 Act and Regulation required the

licensee of a long-term care home to have, institute or otherwise put in place any strategy, the strategy was complied with.

In accordance with O. Reg 79/10, s. 48 (1) 1. and in reference to O. Reg 79/10 s. 49 (1) the licensee was required to ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home, that provided strategies to monitor residents.

Specifically, staff did not comply with the home's policy "Falls Prevention and Management Program #RC-15-01-01", last updated August 2019, which required nursing staff to implement the post-fall clinical pathway and "complete an initial physical and neurological assessment" after a resident has fallen. Appendix five of the policy, "Post Fall Clinical Pathway" (last updated August 2019), indicated that staff were to provide a "focused assessment by the first registered staff person on the scene" and to "reassess for possible injury and pain".

The home submitted a CI report to the Director, which stated that resident #007 had a fall on a specified date. The report indicated that a specified amount of time after the fall, the resident showed signs of injury. The resident was transferred to hospital and diagnosed with a specified injury.

During an interview with PSW #128, they stated, "I think the charge nurse didn't do something [they were] supposed to do". The PSW indicated they were going to assist the resident, a specified time period after the resident's fall, and noticed signs of injury. The PSW noted that they then contacted RPN #124 to inform them.

During an interview with RPN #124, they reported that they had completed a post-fall assessment of resident #007, initially after the fall, while the resident remained in a specified mobility aid.

A review of a specified document indicated that during the home's internal investigation into resident #007's fall, RPN #124 indicated that they had not completed a proper assessment on the resident.

During an interview with RN #125, they stated they completed an initial assessment of resident #007, however no documentation of an assessment could be located from this RN, except for a note completed at a specified time on a specified date, which indicated that the resident was assessed before being sent to hospital. The RN indicated they

could not remember if they had documented their assessment. The RN indicated that the resident remained in a specified state during their assessment, and that they had only completed a specified part of the assessment.

During an interview with RN #116, they reported that where a resident was moved post-fall, it was expected that a full head-to-toe assessment and assessment for injury was completed and that a resident could not be assessed for injury while in a specific state.

During an interview with the DOC, they reported that they were notified after the occurrence of resident #007's fall on a specified date. The DOC noted they had inquired with registered staff as to which assessments were done, and was informed that all assessments had been completed. The DOC further added that the resident should not have been assessed in a specified state. The DOC noted that their internal investigation revealed a complete assessment of the resident was not completed for a specified period, when PSWs noted significant changes to resident #007, and the resident was subsequently transferred to bed. The DOC stated that the home's falls prevention policy was not complied with after resident #007's fall. The DOC added that resident #007's health status was compromised as a result of being left for a specified period prior to being fully assessed by the registered staff. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that where the Act and Regulation require the licensee of a long-term care home to have, institute or otherwise put in place any strategy, that the strategy is complied with, to be implemented voluntarily.

WN #4: 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 resident #007 had fallen, that the resident was assessed, and where the circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate instrument specifically designed for falls.

The home submitted a CI report to the Director, which stated that resident #007 had a fall on a specified date, resulting in injury. Please see WN #3 for details.

A review of the home's policy, "Falls Prevention and Management Program - RC-15-01-01", last updated August 2019, indicated that a nurse involved in post fall management was to implement the post-fall clinical pathway which included the post-fall assessment.

The post-fall assessment instrument dated a specified date, indicated that vitals were completed, the resident was at a specified level of risk for falls, and provided a brief description of the post-fall assessment provided, the root cause of the fall, and who was involved in the post-fall huddle. A number of areas in the assessment were left blank.

During an interview with RN #125, they stated that the RPN or RN staff were to complete the post-fall assessment, and that it was to be completed in full. The RN stated that the assessment was to be completed electronically, and this was the only place the post-fall assessment would be documented. The RN stated that when they asked RPN #124 about completed assessments, they replied they had completed all assessments. In an interview with RPN #124, they confirmed that the RPN was to complete the electronic post-fall assessment.

In an interview with RN #116, after reviewing the electronic post-fall assessment completed on a specified date, they stated that the assessment was incomplete, and that all applicable sections should have been filled out.

During an interview with the DOC, they stated that all post-falls assessments, including the electronic post-fall assessment instrument, were expected to be fully completed and documented, and that this documentation was to be completed electronically. The DOC confirmed that there were blank spaces in the post-fall assessment documentation, and that it was not fully completed. [s. 49. (2)]

Issued on this 6th day of December, 2019

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	MICHELLE BERARDI (679), DAVID SCHAEFER (757), KEARA CRONIN (759), LAUREN TENHUNEN (196), MELISSA HAMILTON (693), STEVEN NACCARATO (744)
Inspection No. / No de l’inspection :	2019_655679_0028
Log No. / No de registre :	006153-19, 006582-19, 010255-19, 015530-19, 017919-19, 020201-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 6, 2019
Licensee / Titulaire de permis :	CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.) 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 Valley Farm Road, PICKERING, ON, L1V-3R6

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Jason Gay

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To CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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 must comply with s. 19. (1) of the Long Term Care Home's Act, 2007.

Specifically the licensee shall,
1) Reeducate all direct care staff on the home's policy regarding reporting incidents of suspected or witnessed abuse and;
2) Maintain a written record of the education provided, which should include the date and the names of the staff who completed the education.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #003, #004, #005, and #011 have been protected from abuse by anyone.

A Critical Incident (CI) report was submitted to the Director on a specified date, indicating that there were separate incidents of alleged staff to resident abuse.

A) Inspector #759 reviewed the CI report that was submitted to the Director. It indicated that RPN #103 witnessed PSW #102 allegedly abusing residents #003, #004 and #005 on separate occasions.

During an interview with PSW #104, they indicated that if they witnessed or were informed of an incident that would be considered abuse, they would report it to their supervisor or the nurse in charge.

Inspectors #759 and #679 interviewed RPN #103, who indicated that if they witnessed anything worrisome it was their duty to report to their supervisor or the Director Of Care (DOC). RPN #103 confirmed that they witnessed the incidents

between PSW #102 and residents #003, #004, and #005. When asked by Inspector #759 if they reported these incidents immediately, they indicated that they reported the last two incidents right away and had not reported the first incident immediately. RPN #103 indicated that they were disciplined for not reporting and completed additional education.

Inspector #759 reviewed a specified document which outlined an interview between the previous Director of Clinical Care #123 and RPN #103. When RPN #103 was asked by the previous Director of Clinical Care #123 why they had not reported the allegations at the time of the incidents, the RPN #103 stated a specified reason.

Inspector #759 reviewed the policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting RC-02-01-01" last revised June 2019. It indicated that "anyone who witnesses or suspects abuse or neglect of a resident by another resident, staff, or other person must report the incident. At minimum, any individual who witnesses or suspects abuse or neglect of a resident must notify management immediately".

During an interview with Inspectors #759 and #679, the DOC indicated that they expected staff to report any suspected or actual abuse immediately to their supervisors, the DOC, or the Administrator. The DOC further indicated that based on the training that RPN #103 had received they should have reported the incidents immediately.

During an interview with the Administrator, they identified that they recalled this CI report, as there were separate incidents reported at once. The Administrator further indicated that they would have expected RPN #103 to report the incidents immediately.

B) During an interview with RPN #103, they revealed additional incidents of potential staff to resident abuse. RPN #103 further indicated that they had not reported the incident that occurred with resident #011 for a specified reason.

During an interview with the DOC, they indicated that based on the training and retraining of RPN #103, that both incidents referenced above should have been reported immediately to the supervisor. The DOC also indicated that they would

submit a CI report and follow up with RPN #103.

On November 12, 2019, Inspector #759 reviewed the Ministry of Long-Term Care's online reporting portal and did not identify any CI reports relating to the above noted incidents.

C) Inspector #759 reviewed the policy titled "Zero Tolerance of Resident Abuse and Neglect Program RC-02-01-01" last updated June 2019. It indicated that "any form of abuse or neglect by any person will not be tolerated" and that "there is a zero tolerance for abuse".

Inspector #759 reviewed a specified document. The document indicated that RPN #103 was in violation of the following policies: Zero Tolerance for Abuse and Neglect, Failure to Report Immediately, Commitment to Resident-Centered Care and Resident's Bill of Rights.

Inspector #759 reviewed a specified document. The document indicated that PSW #102 was in violation of the following policies: Zero Tolerance for Abuse and Neglect, Commitment to Resident-Centered Care, Resident's Bill of Rights.

During an interview with the DOC, they indicated that they believed these incidents occurred as it was reported, and one resident was able to identify PSW #102.

The licensee has failed to ensure that residents #003, #004, #005, and #011, had been protected from abuse by anyone.

The severity of this issue was determined to be a level 2 as there was minimal harm to residents #003, #004, #005, and #011. The scope of the issue was a level 2 as it related to two out of three incidents reviewed. The home had a level 3 compliance history as they had previous non-compliance with this section of the LTCHA which included:
- A Compliance Order (CO) issued on March 9, 2017 (2017_360111_0001) with a compliance due date of June 30, 2017.
(759)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Mar 10, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 6th day of December, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Michelle Berardi

Service Area Office /
Bureau régional de services : Central East Service Area Office

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 6, 2019	2019_655679_0030	015078-19	Follow up

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MICHELLE BERARDI (679), DAVID SCHAEFER (757), KEARA CRONIN (759), LAUREN TENHUNEN (196), MELISSA HAMILTON (693), STEVEN NACCARATO (744)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 4-8, 2019.

The following intake was inspected upon during this Follow Up Inspection.

- One intake related to Compliance Order (CO) #001 from Inspection 2019_670571_0011, regarding section 6. (7) of the Long-Term Care Home's Act, 2007, for care not being provided as specified in the plan of care.

A Critical Incident Report (#2019_655679_0028) and a Complaint Inspection (#2019_655679_0029) were conducted concurrently with this inspection.

PLEASE NOTE: A CO related to s. 6. (7) of the Long-Term Care Home's Act, 2007, identified in a concurrent inspection #2019_655679_0028 was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Acting Assistant Director of Care (AADOC), Registered Nurse (RN) Supervisor, Restorative Care Registered Practical Nurse (RPN), RNs, RPNs, Resident Assessment Instrument (RAI) Coordinator Backup, Housekeeping Aides, Personal Support Workers (PSWs), residents and families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, complaint records, as well as relevant policies and procedures.

Ad-hoc notes were used during this inspection.

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for resident

#007 was provided as specified in the plan.

During inspection #2019_670571_0011, compliance order (CO) #001 was issued to address the licensee's failure to comply with s. 6. (7) of the Long Term Care Home's Act (LTCHA), 2007. The CO ordered the home to:

The licensee must be compliant with s.6 (7) of the LTCHA.

Specifically, the licensee must:
1) Ensure Personal Support Workers (PSW), are made aware that they must follow the plan of care for residents, related to the number of staff members required for personal care, by providing education and a documented record must be kept.

The compliance due date for this order was October 31, 2019.

While the licensee complied with section one of the order, additional non-compliance with the requirements of s. 6 (7) of the Long Term Care Home's Act was identified.

The home submitted a Critical Incident (CI) report to the Director, which indicated that resident #007 had a fall on a specified date. The fall resulted in a transfer to hospital where it was determined that the resident had a specified injury.

Inspector #757 reviewed resident #007's current care plan, which indicated that staff were to ensure that a specified intervention was in place at specified times.

During an observation on a specified date, resident #007 was noted to be in their room and their specified intervention was not in place. Upon further observations, the resident's specified intervention was observed to be located in another area of the resident's room.

During an interview with PSW #126, they confirmed that the resident's intervention was not in place as specified in the care plan.

During an interview with RPN #127, they indicated that resident #007 required a specified intervention The RPN noted that if the resident was in their room without the specified intervention in place, then care was not provided according to the plan of care.

During an interview with RN #125, they indicated that resident #007's specified

intervention should have been in place in order to provide care as specified in the plan of care.

During an interview with the Director Of Care (DOC), they confirmed that resident #007's specified intervention should have been in place as per the care plan. [s. 6. (7)]

2. A CI report was submitted to the Director related to a fall of resident #008 resulting in an injury.

Inspector #744 reviewed resident #008's current care plan, which indicated that staff were to implement two specified interventions.

Inspector #744 observed resident #008 on two occasions without the two specified interventions in place. This observation was confirmed by PSW #109.

In an interview with Inspector #744, PSW #109 stated that one of the specified interventions for resident #008 had been missing for a specified period of time and that the other intervention was unable to be implemented due to a specified reason.

In an interview with Inspector #744, the DOC stated that staff were to ensure that the interventions listed in the care plan were always in place. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 6th day of December, 2019

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	MICHELLE BERARDI (679), DAVID SCHAEFER (757), KEARA CRONIN (759), LAUREN TENHUNEN (196), MELISSA HAMILTON (693), STEVEN NACCARATO (744)
Inspection No. / No de l’inspection :	2019_655679_0030
Log No. / No de registre :	015078-19
Type of Inspection / Genre d’inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Dec 6, 2019
Licensee / Titulaire de permis :	CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.) 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 Valley Farm Road, PICKERING, ON, L1V-3R6

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Jason Gay

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To CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2019_670571_0011, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the Long Term Care Homes Act 2007.

Specifically, the licensee shall:
1) Develop an auditing tool and schedule to ensure that residents #007, #008, and all residents of the home who are at a high risk for falls receive care as specified in their care plan; and

2) Maintain records of the audits and the actions taken to rectify identified deficiencies. The records shall include the date, time, location, residents involved, staff involved, the name and classification of the person completing the audit, any corrective actions taken and the outcome.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #007 was provided as specified in the plan.

During inspection #2019_670571_0011, compliance order (CO) #001 was issued to address the licensee's failure to comply with s. 6. (7) of the Long Term Care Home's Act (LTCHA), 2007. The CO ordered the home to:

The licensee must be compliant with s.6 (7) of the LTCHA.

Specifically, the licensee must:
1) Ensure Personal Support Workers (PSW), are made aware that they must

follow the plan of care for residents, related to the number of staff members required for personal care, by providing education and a documented record must be kept.

The compliance due date for this order was October 31, 2019.

While the licensee complied with section one of the order, additional non-compliance with the requirements of s. 6 (7) of the Long Term Care Home's Act was identified.

The home submitted a Critical Incident (CI) report to the Director, which indicated that resident #007 had a fall on a specified date. The fall resulted in a transfer to hospital where it was determined that the resident had a specified injury.

Inspector #757 reviewed resident #007's current care plan, which indicated that staff were to ensure that a specified intervention was in place at specified times.

During an observation on a specified date, resident #007 was noted to be in their room and their specified intervention was not in place. Upon further observations, the resident's specified intervention was observed to be located in another area of the resident's room.

During an interview with PSW #126, they confirmed that the resident's intervention was not in place as specified in the care plan.

During an interview with RPN #127, they indicated that resident #007 required a specified intervention The RPN noted that if the resident was in their room without the specified intervention in place, then care was not provided according to the plan of care.

During an interview with RN #125, they indicated that resident #007's specified intervention should have been in place in order to provide care as specified in the plan of care.

During an interview with the Director Of Care (DOC), they confirmed that resident #007's specified intervention should have been in place as per the care

plan. (679)

2. A CI report was submitted to the Director related to a fall of resident #008 resulting in an injury.

Inspector #744 reviewed resident #008's current care plan, which indicated that staff were to implement two specified interventions.

Inspector #744 observed resident #008 on two occasions without the two specified interventions in place. This observation was confirmed by PSW #109.

In an interview with Inspector #744, PSW #109 stated that one of the specified interventions for resident #008 had been missing for a specified period of time and that the other intervention was unable to be implemented due to a specified reason.

In an interview with Inspector #744, the DOC stated that staff were to ensure that the interventions listed in the care plan were always in place.

The severity of this issue was determined to be a level 2 as there was minimal risk to residents #007 and #008. The scope of the issue was a level 2 as it related to two of four residents reviewed. The home had a level 5 compliance history as they had ongoing non-compliance with this section of the LTCHA and four or more compliance orders that included:
- A Written Notification (WN) issued on March 9, 2017 (2017_360111_0001)
- A Director's referral (DR) with CO issued on November 8, 2017 (2017_643111_0013) with a compliance due date of November 15, 2017;
- A Voluntary Plan of Correction (VPC) issued on March 21, 2019 (2019_598570_0005); and,
- A Compliance order (CO) issued on July 25, 2019 (2019_670571_0011) with a compliance due date of October 31, 2019.
(679)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 21, 2020

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 6th day of December, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Michelle Berardi

Service Area Office /
Bureau régional de services : Central East Service Area Office

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 6, 2019	2019_655679_0029	010139-19	Complaint

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MICHELLE BERARDI (679), DAVID SCHAEFER (757), KEARA CRONIN (759), LAUREN TENHUNEN (196), MELISSA HAMILTON (693), STEVEN NACCARATO (744)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 4-8, 2019.

The following intake was inspected upon during this Complaint Inspection:

- One intake related to resident care concerns.

A Critical Incident Inspection (#2019_655679_0028) and a Follow Up Inspection (#2019_655679_0030) were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Acting Assistant Director of Care (AADOC), Registered Nurse (RN) Supervisor, Restorative Care Registered Practical Nurse (RPN), RNs, RPNs, Resident Assessment Instrument (RAI) Coordinator Backup, Housekeeping Aides, Personal Support Workers (PSWs), residents and families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, complaint records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 :

1. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A complaint was submitted to the Director regarding care concerns for resident #002.

Inspector #693 reviewed resident #002's care plan. The care plan indicated that resident #002 required specified continence interventions.

Inspector #693 reviewed the home's complaints binder and identified a complaint made to the Director of Clinical Care (DOCC) on a specified date, which indicated that resident #002 was found in a specified state.

During an interview with PSW #115, they stated that for any resident who required a specified continence intervention, the continence care was documented in the resident's health care record. The PSW stated that the home started using a different documentation system in a specified month, and before continence routines were documented on a paper record.

Inspector #693 reviewed the home's investigation notes which contained copies of resident #002's continence record for a specified month. Inspector #693 identified that on a specified date, the continence record was left blank. In addition, the Inspector noted that on specified dates and times the continence record for resident #002 was left blank.

During an interview with PSW #106, they stated that they were responsible for caring for resident #002 on a specified shift. They stated that they knew that resident #002 required a specified continence intervention, but that they did not have time to implement the intervention as per the care plan. Together with the Inspector, PSW#106 reviewed resident #002's continence record for a specified month, and confirmed that on a specified date, they had not documented any continence care that was provided to resident #002.

During an interview with the Acting Assistant Director Of Care (AADOC), they stated that staff chart a resident's continence routine in the resident's health care record, as indicated by the resident's care plan. The AADOC stated that for resident #002 staff chart at a specified frequency if they provided the resident with continence assistance as per the resident's continence plan. The AADOC provided the Inspector with a specified report for resident #002 related to continence care.

Inspector #693 reviewed the report as provided by the AADOC for resident #002, over a specified period, and identified that resident #002 was to be provided with a specified continence intervention. The corresponding documentation, by PSW staff was for the number of minutes spent on continence with the resident, and the documented times did not meet the times of the outlined intervention. In review of the specified report for resident #002, relating to continence, it could not be identified the number of times resident #002 was assisted with continence care over a specified period.

Inspector #693 reviewed the home's policy, titled, "Care Planning RC-05-01-01", last updated in June, 2019. The policy indicated that the plan of care served as a communication tool which enhanced the provision of individualized care, assisted in the provision of continuity of care as all team members were aware of the individualized plan, promoted safe and effective resident care and provided documentation.

Inspector #693 reviewed the home's policy, titled, "Daily Personal Care and Grooming, RC-06-01-01", last updated June 2019. The policy indicated that nurses and care staff were to document care provided to indicate care given or refused on the resident's medical record.

During an interview with the DOC, they stated that when a resident required a specified continence intervention, PSW staff were responsible to document in the resident's health care record as per the resident's individualized plan. The DOC stated that the home switched to a different documentation system in a specified month, and before that staff documented continence interventions on paper records for each individual resident. Together with the Inspector, the DOC reviewed resident #002's continence record, for a specific month, and confirmed that on a specified date, the continence record was left blank. The DOC further confirmed the additional times in which documentation was missing related to resident #002's continence intervention. The DOC confirmed that the documented reports and the task charting in the resident's health care record did not reflect the care as outlined in the plan of care for resident #002's continence routine, as they were not specific to if the resident was assisted as per the plan of care. The DOC called the Restorative RPN #120 to review the documentation for resident #002. The DOC stated that the Restorative RPN #120 was responsible for auditing documentation for a specified program. Restorative RPN #120 reviewed the documentation and confirmed that the documentation was not reflective of the continence care as outlined in the plan of care for resident #002. The DOC then called the RAI Coordinator Backup #121 to review the documentation for resident #002. The DOC, Restorative RPN #120 and the RAI Coordinator Backup #121 agreed and confirmed that the documentation for

resident #002 was not reflective of the continence care provided as outlined in the resident's plan of care, for a specified period. [s. 6. (9) 1.]

2. Inspector #693 reviewed resident #010's care plan which indicated that resident #010 required specified continence interventions.

During an interview with the RAI Coordinator Backup #121, they stated that resident #010 required a specified continence intervention, and that PSW staff charted the continence intervention in the resident's health care record. RAI Coordinator Backup #121 indicated that in addition, the PSWs would chart sleeping or refused on times that the resident was not assisted with continence.

Together with the Inspector, the RAI Coordinator Backup#121, Restorative RPN #120, and the DOC reviewed the documentation for resident #010 for a specified period. The DOC confirmed that the documentation was not reflective of the continence routine outlined in the plan of care for resident #010 as the documentation only showed the number of minutes staff spent assisting the resident and the level of assistance the resident needed with their continence, but did not show when the continence intervention was completed. In addition, the DOC identified that if staff had documented later in the day for care provided at an earlier time, the documentation would not reflect when the care was provided, and that on times that the continence intervention wasn't documented or was missed the staff had not always documented that the resident was asleep or refused the care; in conclusion for each day over a specified period, resident #010's provision of their individualized continence routine, was not documented in accordance with their plan of care. [s. 6. (9) 1.]

3. Inspector #693 reviewed resident #009's care plan, which indicated that they required specified continence interventions.

During an interview with the RAI Coordinator Backup #121, they stated that resident #009 required a specified continence intervention, and that PSW staff charted the continence intervention in the resident's health care record.

Together with the Inspector, the RAI Coordinator Backup#121, Restorative RPN #120, and the DOC reviewed the documentation for resident #009 over a specified period. The DOC confirmed that the documentation was not reflective of the continence routine outlined in the plan of care for resident #009, as the documentation only showed the number of minutes staff spent assisting the resident and the level of assistance the

resident needed with continence, but did not show when this resident was provided with the continence intervention. Further, if staff documented later in the day for care provided at an earlier time, the documentation would not reflect when the care was provided and that on times that continence care wasn't documented or was missed the staff had not always documented that the resident was asleep or refused the care. The DOC verified that on each day for a specified period, resident #009's provision of their individualized continence routine, was not documented in accordance with their plan of care. [s. 6. (9) 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 ensuring that the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A complaint was submitted to the Director regarding care concerns for resident #002.

Inspector #693 reviewed resident #002's care plan. The care plan indicated that resident #002 required specified continence interventions.

Inspector #693 reviewed the home's complaints binder and identified a complaint made to the DOCC on a specified date, which indicated that resident #002 was found in a specified state.

Inspector #693 reviewed the home's investigation notes, which contained photographs of resident #002. The photographs showed a specified continence intervention in a certain state. The notes indicated that the DOCC met with PSW #106 (who was assigned to assist resident #002), and that PSW #106 stated that they thought the resident had been provided care at an earlier time, and that they later assisted the resident at a specified time. PSW #106 stated they did not provide any care to the resident after a specified time for specified reasons. The investigation notes indicated that PSW #106 would receive discipline for not assisting resident #002 as per their care plan.

Inspector #693 reviewed a specific document. The document identified that resident #002's care plan indicated that they required a specified continence intervention. The document indicated that PSW #106 did not provide the continence intervention as outlined in the care plan.

During an interview with PSW #106, they stated that they were responsible for caring for resident #002 on a specified shift. They stated that they knew that resident #002 required a specified continence intervention, but that they did not have time to implement the intervention as per the care plan. The PSW stated that they checked the resident at a specified time, but they did not provide continence assistance to them at this time.

Inspector #693 reviewed, the home's policy, titled, "Continence Management Program, RC-14-01-01", last revised in August, 2018. The policy identified that care staff were to follow the resident's plan of care in relation to the continence management program. The "Scheduled Toileting and Bladder Retraining Routines" portion of the Continence program stated that staff were to toilet the resident at times based on the individual resident's pattern for residents on a scheduled toileting routine.

During an interview with the DOC, they stated that on a specified shift resident #002's care plan relating to continence was not implemented because the resident was only assisted with continence a specified amount of times, and should have received assistance as per their plan of care relating to continence. The DOC stated that although PSW #106 did state that they checked the resident, this was still not following the continence care plan as the resident was not provided with assistance as per their plan of care. [s. 51. (2) (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 ensuring that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident had occurred, or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A complaint was submitted to the Director regarding care concerns for resident #002.

Inspector #693 reviewed resident #002's care plan. The care plan indicated that resident #002 required specified continence interventions.

Inspector #693 reviewed the home's complaints binder and identified a complaint made to the DOCC on a specified date, which indicated that resident #002 was found in a specified state.

Inspector #693 reviewed the home's investigation notes, which contained photographs of resident #002. The photographs showed a specified continence intervention in a certain state. The notes indicated that the DOCC met with PSW #106 (who was assigned to assist resident #002), and that PSW #106 stated that they thought the resident had been provided care at an earlier time, and that they later assisted the resident at a specified time. PSW #106 stated they did not provide any care to the resident after a specified time for specified reasons. The investigation notes indicated that PSW #106 would receive discipline for not assisting resident #002 as per their care plan.

Inspector #693 reviewed a specific document. The document identified that resident #002's care plan indicated that they required a specified continence intervention. The letter indicated that PSW #106 did not provide the continence intervention as outlined in the care plan. See WN #2 for further details.

During an interview with PSW #106, they stated that they were responsible for caring for resident #002 on a specified shift. They stated that they knew that resident #002 required a specified continence intervention, but that they did not have time to implement the intervention as per the care plan. The PSW stated that they checked the resident at a specified time, but they did not provide continence assistance to them at this time.

Inspector #693 reviewed the home's policy, titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, RC-02-01-01", last updated in June 2019. The policy indicated that in Ontario, anyone who suspected or witnessed incompetent care or treatment of a resident that caused or may cause harm to the resident is required to contact the MLTC through the Action Line. The policy identified that the DOC or designate was responsible for following province specific reporting requirements. Inspector #693 reviewed Appendix 2, titled, "Jurisdictional Reporting Requirements", last updated in June 2019, the appendix identified that mandatory reporting under the LTCHA: Section 24 (1) of the LTCHA required a person to make an immediate report to the Director where there is reasonable suspicion that certain incidents occurred or may have occurred. The LTCHA provided that any person who had reasonable grounds to

suspect that any of the following had occurred, or may occur, must immediately report the suspicion and the information upon which it is based to the Director of the MLTC: improper or incompetent treatment or care of a Resident that resulted in harm or a risk of harm to the Resident.

During an interview with the DOC, they stated that if a resident was to be provided with continence assistance at a specified frequency and was only provided with assistance a specified amount of time during the shift, then that would be an example of improper care. Inspector #693 and the DOC reviewed the complaint and investigation notes for resident #002, from the complaint made. The DOC stated that it was the home's obligation to mandatory report the improper care that occurred from resident #002 not being provided their continence interventions in accordance with their continence care plan. The DOC confirmed that no CI report or Action Line notification was made for this incident of improper care and that a CI report should have been submitted. [s. 24. (1)]

Issued on this 9th day of December, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 26, 2020	2020_838760_0006	021574-19, 023186-19, 023988-19, 002149-20	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JACK SHI (760), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 25, 26, 27, 28, and March 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 2020

The following intakes were completed in this critical incident system inspection:
Log related to a suspected improper transfer resulting in injury.
Log related to allegations of staff to resident abuse.
Log related to a suspected improper transfer resulting in injury.

A follow up to Compliance Order (CO) #001, s. 19, related to resident abuse, issued under inspection #2019_655679_0028, on December 6, 2019, with a compliance date of March 10, 2020, was inspected.

A Complaints inspection #2020_838760_0005 was conducted concurrently with this Critical Incident Systems inspection.

PLEASE NOTE: A WN related to s. 6 (7) was identified in this inspection and has been issued in Inspection Report #2020_838760_0005 dated on May 26, 2020, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Behavioural Supports Ontario Personal Support Worker (BSO PSW), Housekeepers, Laundry Aides, Director of Clinical Care (DOCC), Housekeeping Manager, Environmental Supervisor, Director of Care (DOC), Administrator, residents, and Substitute Decision Makers (SDM).

During the course of the inspection, the inspector(s) conducted observations, record reviews and interviews.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Training and Orientation

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2019_655679_0028	760

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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policies, that the policy was complied with.

In accordance with Ontario Regulation 79/10 s. 50. (2) (b), every licensee of a long-term care home shall ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of the licensee's policy, titled Skin and Wound Program: Prevention of Skin Breakdown, last updated December 2019, indicated the following:
- Nurse/Interdisciplinary team were to promptly assess/address all skin concerns reported by the care staff; determine the root cause of the skin injury and put in place preventative strategies to avoid reoccurrence or further injury, document changes in resident's skin condition in the progress notes and wound records where applicable; Notify resident/Power of Attorney (POA)/SDM/family of any or new worsening skin/wound conditions and interventions in place.

- Care staff were to observe residents' head to toe skin condition during the provision of care; document altered skin integrity in the Daily Care Record or electronic equivalent; promptly report verbally any changes (e.g. redness, bruises, skin tears) to the nurse.

A Critical Incident Report (CIR), was submitted to the Director related to the incompetent care of resident #001. The CIR indicated that the SDM of resident #001 reported to RPN #119 that resident #001 had an identified altered skin integrity. RPN #128 informed the SDM that there was no documentation completed for the identified altered skin integrity.

Inspector #570 reviewed the home's internal investigation file related to the CIR. In the investigation, RPN #119 had indicated to the home that they had forgotten to check on resident #001's altered skin integrity when it was reported by the resident's SDM.

Inspector #570 reviewed progress notes for resident #001. The review indicated that RPN #128 documented that the resident's SDM reported the resident had an altered skin integrity issue in an identified location of their body. RPN #128 assessed the area and initiated continued monitoring of this area, using the electronic Treatment Administration Record (E-TAR) system.

A review of E-TAR for resident #001 indicated to monitor the area of altered skin integrity until healed.

Inspector #570 reviewed electronic records for resident #001. The review did not indicate a report, nor a skin assessment was completed for resident #001's altered area of skin integrity when it was reported by the SDM .

During separate interviews by Inspector #570 with RPN #106 and RN #107, they indicated that the practice in the home is to ensure that once registered staff becomes aware of an altered skin integrity issue, it should be assessed and documented electronically which also includes completing a skin assessment and notification of the SDM of the resident. During the interview, RN #107 indicated when they were first notified of resident #001's altered skin integrity issue, they did not assess the resident. RN #107 further indicated that when they assessed the resident at a later period, they could not find any altered skin integrity issues.

In an interview with the DOC, they indicated to Inspector #570, that RPNs #119 and #128 did not follow the home's policy when RPN #119 did not assess resident #001's altered skin integrity with no documentation noted; and RPN #128 did not complete a

skin assessment and did not initiate an electronic report.

The licensee's policy, titled Skin and Wound Program: Prevention of Skin Breakdown was not complied with when resident #001's altered skin integrity was not assessed. [s. 8. (1) (b)]

2. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policies, that the policy was complied with.

A CIR was submitted to the Director related to the incompetent care of resident #002. The CIR indicated indicated RPN #122 was notified that resident #002 sustained an altered skin integrity issue on an identified location on their body. After a period of time, the resident was assessed by the physician and further medical assessments were rendered. Skin and pain assessments were completed and the resident's SDM was notified at that point.

Inspector #570 reviewed the home's internal investigation file related to the CIR. In the investigation, RPN #122 had indicated to the home that they had seen identified concerns related to the altered skin integrity and put it in the doctor's book but did not document in their chart, did not report to the supervisor and did not notify resident #002's SDM.

Inspector #570 reviewed resident #002's clinical chart. The review indicated the identified concerns related to the altered skin integrity was assessed by the physician a few days after RPN #122 first discovered it. The record review indicated no skin assessment was completed, no monitoring and no interventions were put in place until a few days after the resident was seen by the physician.

In an interview by Inspector #570 with RPN #122, they acknowledged that when PSW staff first reported that resident #002 had an altered skin integrity issue, RPN #122 wrote a note in the doctor's book to assess the resident. RPN #122 acknowledged they did not initiate a report, did not complete skin assessment, did not inform their supervisor, and did not notify the SDM. RPN #122 further indicated that they worked a number of shifts between when resident #002's altered skin integrity was first identified to when the doctor assessed the resident and did not do any follow up documentations between that period. The RPN indicated that they should have called the supervisor for directions.

In an interview by Inspector #570 with RN #120, they indicated they became aware of the resident's altered skin integrity by reading the report book on the date that the doctor assessed the resident. RN #120 indicated they completed a skin assessment for the resident when they first became aware of the issue. The RN indicated that RPN #122 should have called the doctor and informed the supervisor on duty for directions.

In an interview by Inspector #570 with the DOC, they confirmed the skin and wound policy was not followed when no skin assessment was completed, no pain assessment was completed, and the resident's SDM was not notified when PSW staff first reported resident #002's altered skin integrity to RPN #122. The DOC further indicated that none of PSW staff documented any skin observations for resident #002 related to their altered skin integrity.

The licensee's policy, titled Skin and Wound Program: Prevention of Skin Breakdown was not complied with when resident #002's altered skin integrity was not assessed. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure 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 (b) is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that an allegation of abuse and improper treatment of resident #006 by staff was reported immediately to the Director.

A CIR was submitted by the home, related to allegations of staff to resident verbal and physical abuse that occurred in a previous period and was captured by a video camera.

A record review indicated resident #006's SDM sent emails to the home at various dates and times, though all within a similar time frame, in relation to footage of the allegation of abuse and improper treatment of resident #006.

An interview with DOC #114 indicated that these incidents occurred all around the same time and it was initially reported by resident #006's SDM to the home’s previous DOCC, Administrator #130 and programs manager.

Administrator #130 indicated they were in the progress of transitioning into the new administrator of the home when they became aware of this allegation of abuse with resident #006. Administrator #130 indicated that the previous DOCC of the home was in charge of the investigation and did not follow the home’s expectations when it came to reporting this allegation to the Director.

DOC #114 stated that the CIR was submitted to the Director after a period of time passed from when these incidents occurred and when the home became aware of them. DOC #114 and Administrator #130 indicated that this incident of alleged staff to resident abuse and incompetent treatment should have been reported to the Director immediately.

The licensee failed to ensure that the allegation of abuse and improper treatment of resident #006 was immediately reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that 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. 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that when resident #006 was taking any drug, there was documentation of the resident's response and the effectiveness of the drugs.

A CIR was submitted by the home, related to allegations of staff to resident verbal and physical abuse and incompetent treatment that occurred in a previous period and was captured by a video camera.

A record review of the progress notes for resident #006 indicated RPN #128 documented an administration of an as-needed medication to the resident, as per their request. After a period of time, RPN #128 documented an effectiveness with the as-needed medication and followed up with a documented reassessment. Later on that same shift, RPN #128 documented another administration of the same as-needed medication for resident #006 but did not document its effectiveness on their shift; the registered staff who worked the next shift documented the effectiveness was unknown.

A review of the home's policy titled, "PRN Medications", indicates that staff are to document the reason for administration and its effectiveness on the electronic Medication Administration Record (eMAR).

Inspector #760 and DOCC #125 reviewed the video footage submitted by resident #006's SDM without audio due to technical issues. RPN #128 and resident #006 appeared gesture at the RPN and a period after, RPN #128 proceeds to provide resident #006 with their medication. DOCC #125 stated RPN #128 did not go back into resident #006's room to reassess them.

RN #117 indicated during their interview that the home's expectations and policy indicates that after 30-60 minutes passed since the administration of an as-needed pain medication, a follow up reassessment needs to be performed with the resident.

An interview with DOC #114 indicated that the home's expectations for post administration of an as-needed medication would be to go back into the resident's room and involve the resident in the assessment and document their response accordingly. DOC #114 stated that RPN #128 did not go back into resident #006's room after administering the as-needed medication and stated that the footage in the video did not match with what RPN #128 documented in their progress note. DOC #114 confirmed RPN #128 failed to document resident #006's response and effectiveness of taking an as-needed medication.

The licensee failed to ensure that resident #006's response and effectiveness of taking an as-needed pain medication was documented. [s. 134. (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 when a resident is taking any drug or combination of drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #006 was protected from verbal and physical abuse from PSW #118 and PSW #127.

A CIR was submitted by the home, related to allegations of staff to resident abuse that occurred in a previous period and was captured by a video camera.

A record review of resident #006's written plan of care around the time of these incidents indicates that the resident demonstrates responsive behaviours. The interventions listed indicate to have staff respond accordingly depending on their responsive behaviours and this included responding to their call bell promptly. The interventions also included to ensure that two staff were present for care at all times.

A review of the home's investigation notes related to this incident indicated that PSW #118 was responded to resident #006's call bell after multiple previous calls. PSW #118 went into their room and questioned the resident's use of the call bell. DOC #114 indicated that PSW #118's body language was inappropriate and slammed the resident's door after they left. PSW #118 was disciplined and apologized for their actions.

A review of the home's investigation notes related to PSW #127 indicated that the resident was telling PSW #127, "two staff, two staff" and was attempting to refuse the care from PSW #127 but they held stopped them from refusing and proceeded to provide care to the resident.

Inspector #760 and DOCC #125 reviewed the video footage from PSW #118 and PSW #127 and was unable to hear the communication between the staff members and resident, due to technical issues. Inspector observed PSW #118 walking towards resident #006 and made a gesture at the resident. According to DOCC #125, during this encounter, PSW #118 made a remark to the resident about the use of their call bell. Inspector also observed PSW #127 preparing the care for resident #006, but resident #006 gestured to PSW #127, indicating they did want the care to proceed, as they wanted two staff members present. PSW #127 ignored this request from resident #006 and continued with the care by physically restraining resident #006.

During an interview with Inspector #760, PSW #118 indicated they attended to resident #006's room multiple times during their shift. During one of those encounters, they pointed at the resident and slammed the resident's door when they left. PSW #118 stated that this was inappropriate interaction with resident #006.

DOC #114 indicated in their interview that the home's expectations was for staff to answer a resident's call bell right away and when they enter their room, the staff should start by introducing themselves and attempt to figure out what the resident needs are and provide the required assistance. DOC #114 confirmed that when PSW #118 went into resident #006's room after multiple previous calls, they questioned resident #006's use of their call bell and turned off the lights and slammed the door when they left. Furthermore, DOC #114 confirmed when resident #006 demonstrated to PSW #127 that they did not want to proceed with their care because they wanted two staff present, PSW #127 continued with their care and physically restrained the resident. DOC #114 confirmed that the home failed to ensure resident #006 was protected from verbal and physical abuse from PSW #118 and PSW #127.

The licensee failed to ensure resident #006 was protected from verbal and physical abuse from PSW #118 and PSW #127. [s. 19. (1)]

Issued on this 5th day of June, 2020

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 26, 2020	2020_838760_0005	022070-19, 022624-19, 023183-19, 001230-20	Complaint

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JACK SHI (760)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 25, 26, 27, 28 and March 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 2020

The following intakes were completed in this complaint inspection:
Log related to missing baths.
Log related to availability of supplies.
Log related to various care concerns..

A follow up to Compliance Order (CO) #001, s. 6 (7), related to providing care set out in the resident's plan of care, issued under inspection #2019_655679_0030, on December 6, 2019, with a compliance date of Feb 21, 2020, was inspected.

A Critical Incident System inspection #2020_838760_0006 was conducted concurrently with this Complaint inspection.

PLEASE NOTE: A WN related to s. 6 (7), identified in a concurrent inspection #2020_838760_0006 was issued in this report.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Behavioural Supports Ontario Personal Support Worker (BSO PSW), Housekeepers, Laundry Aides, Director of Clinical Care (DOCC), Housekeeping Manager, Environmental Supervisor, Director of Care (DOC), Administrator, residents, and Substitute Decision Makers (SDM).

During the course of the inspection, the inspector(s) conducted observations, record reviews and interviews.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2019_655679_0030	760

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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident received a bath, at a minimum of

twice a week.

The Ministry of Long-Term Care (MLTC) received a complaint from the SDM of resident #003 regarding concerns of the home's short staffing, which resulted in resident #003 not receiving their scheduled baths.

A record review of the home's staffing plan, titled "Nursing- Staffing Contingency Plan- Orchard Villa Long Term Care", indicates that when the home is short of one PSW on a unit, they are to continue to provide scheduled baths to residents.

A review of resident #003's current written plan of care indicated that resident #003 receives their scheduled showers, twice a week. A further record review on the electronic documentation system, Point of Care (POC), indicated the PSW documented the activity did not occur, related to the bathing task on an identified date for resident #003. A review of resident #003's progress notes and chart did not produce information related to why resident #003 did not receive their scheduled bath or whether a bath was given the following day, within the same week.

Record reviews of the staffing schedule on that identified date where resident #003 did not receive their shower indicated that there were four PSWs who worked on that shift and on resident #003's unit.

An interview with RPN #111 indicated resident #003's unit has a regular staffing complement of five PSW and two RPN's. RPN #111 stated that if a bath is missed due to short staffing, a staff member will be brought in either on the next shift or the following day to complete the missed baths. The registered staff will inform the resident's family member and document it in the progress notes afterwards. RPN #111 indicated that if a bath is given on an alternate date, this would be documented on the POC system by the PSW's. RPN #111 confirmed resident #003 received one bath on an identified week.

An interview with DOC #114 indicates that when a unit is short of one PSW, the home's expectations would be to continue to provide care to all residents, as per their plan of care, including providing baths, if they are scheduled on that day. DOC #114 confirmed that the home does experience a shortage of staff. DOC #114 stated that if a bath was given to a resident on an alternate day, the home's expectation would be for the staff to document it on the POC system and a registered staff would communicate this with the resident's SDM and document it afterwards. DOC #114 confirmed that resident #003 did

not receive two baths on an identified week.

The licensee failed to ensure that resident #003 receive a minimum of two baths on an identified week. (760) [s. 33. (1)]

2. Resident #004 was selected for sample expansion related to non-compliance identified related to baths not provided to resident #003.

A record review of resident #004's current written plan of care indicated that they are to receive two baths a week.

A review of the documentation on POC indicated that staff documented the activity did not occur, related to the bathing task on multiple identified dates. A review of resident #004's progress notes and chart did not produce information related to why resident #004 did not receive their scheduled bath or whether a bath was given on an alternate day, during the weeks of those days where they did not receive a bath.

An interview RPN #113 identified that there were some dates where they worked with one less PSW than their regular staffing complement, specific to those dates and shifts where resident #004 did not receive their scheduled bath. However, RPN #113 stated that they seldomly work with a full staffing complement but continue to provide care accordingly to residents, despite having less staff than the usual complement. RPN #113 indicates that if they have one less staff than the regular staffing complement, they are still expected to provide baths to residents, as per their bath schedule.

RN #107 was interviewed and stated resident #004 was supposed to receive two scheduled baths per week. RN #107 stated that on multiple identified weeks, the resident did not receive their two scheduled baths.

An interview with DOC #114 indicated that if resident #004's unit was down one PSW, there would be two RPN's scheduled on the unit to assist, thus the home's expectation would be to continue to provide resident #004 with their scheduled bath. DOC #114 confirmed that resident #004 did not receive two baths on multiple identified weeks.

The licensee failed to ensure that resident #004 received, at a minimum, two baths during multiple identified weeks. (760) [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations between resident #008 and co-residents in the dining room by implementing interventions.

The MLTC received a complaint from the family member of resident #008 related to various areas of their care including concerns over resident #008's responsive behaviours and how the home manages them. The family member indicated they witnessed an altercation between resident #008 and a co-resident, where resident #008 threw an object at the co-resident, hitting them on an identified body part.

A record review of resident #008's written plan of care identified that they can demonstrate responsive behaviours. There were no interventions identified in resident #008's written plan of care, specific to their responsive behaviours that they demonstrate

during an identified time.

A review of the progress notes for resident #008 indicated they used an object to hit resident #010 on an identified body part. A review of the incident form completed by staff indicate that the responsive behaviours may have been caused by resident #010 triggering resident #008 through an prior interaction.

A review of the progress notes indicates resident #008 was involved in another altercation with resident #009 and threw an object at them. A review of the incident form indicated that staff attempted to move resident #009 away from resident #008 but this did not work which resulted in resident #008's actions.

An interview with the current DOCC #125 (who was the home's previous Behavioural Supports Ontario Registered Practical Nurse) indicated that interventions would be implemented right after an altercation occurs between two co-residents and that a resident's plan of care would be updated to reflect these new interventions. DOCC #125 reviewed resident #008's written plan of care and confirmed that there were no new interventions implemented following these two incidents.

During an interview, DOC #114 indicated that it is the responsibility of staff to ensure that a resident's plan of care becomes updated with interventions following an altercation between two co-residents, in order to prevent a future re-occurrence. DOC #114 reviewed resident #008's plan of care and confirmed that there were no new interventions implemented following these two incidents. DOC #114 and Inspector #760 noted that resident #008's written plan of care was updated with interventions and triggers related to these two incidents, by DOCC #125 after their interview with Inspector #760 and DOC #114 indicated the interventions should have been in place right after these incidents occurred.

The licensee failed to ensure that interventions were implemented to reduce the risk of altercations between resident #008 with resident #009 and resident #010. (760) [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in resident #008's plan of care was being provided.

The MLTC received a complaint from the family member of resident #008 related to various areas of their care including the application of fall prevention interventions for the resident.

A record review of resident #008's written plan of care states that staff are to ensure that resident #008 has a fall prevention intervention on at all times due to their risk for falls.

An observation made by Inspector #760 with resident #008 noted they were with PSW #131 and was coming out of a room after receiving care. Resident #008 did not have their fall prevention intervention on at that time. RPN #132 instructed PSW #131 to apply the fall prevention intervention on resident #008 after Inspector #760 was seen observing the resident without it. After the application of the fall prevention intervention, resident #008 did not make any attempts to take it off.

In an interview with PSW #131, they indicated that resident #008 was demonstrating

responsive behaviours earlier in the day and PSW #131 did not ask resident #008 if they wanted their fall prevention intervention applied. PSW #131 confirmed that resident #008 did not have their fall prevention intervention on prior to receiving care that the inspector witnessed them coming out of. RPN #132 stated that resident #008 was supposed to have their fall prevention intervention on at all times except for at bedtime.

An interview with DOC #114 indicated that if a resident's plan of care states that a fall prevention intervention was to be applied at all times, the staff should be applying it for the resident at all times as well. DOC #114 confirmed that resident #008's written plan of care indicates that they should have their fall prevention intervention on at all times and the home's expectations would be for registered staff and PSW's to follow their plan of care at all times. DOC #114 confirmed the home failed to provide the care set out in resident #008's plan of care, as it relates to the application of their fall prevention intervention.

The licensee failed to ensure that resident #008 was provided the care set on in their plan of care, as it relates to the application of their fall prevention intervention. (760) [s. 6. (7)]

2. The licensee failed to ensure that resident #006's care set out in their plan of care was provided.

A Critical Incident Report (CIR) was submitted by the home, related to allegations of staff to resident abuse that occurred in a previous period and was captured by a video camera.

A record review of resident #006's written plan of care around the time of these incidents indicates that the resident required two staff members for assistance due to their responsive behaviours. The written plan of care indicates that staff are to leave resident #006's room if they refuse their care and re-approach afterwards. Furthermore, it states that staff need to assess resident #006's mood before proceeding with their care and report all care refusals to the registered staff and the SDM.

A review of the home's investigation notes indicated PSW #127 acknowledged during the care for resident #006, PSW #127 did not listen to the resident, when they asked for two staff members to be present for their care. PSW #127 indicated that a second PSW was not present during the provision of care to resident #006.

Inspector #760 and DOCC #125 reviewed the video footage from PSW #127 providing care to resident #006 and prior to beginning the care, resident #006 made a gesture to PSW #127. Inspector #760 was unable to hear the communication between the staff members and resident, due to technical issues.

An interview with PSW #116 indicated resident #006 required two staff assistance for care and would ring their call bell if the resident required assistance.

Interview with DOC #114 stated that PSW #127 proceeded to provide care to resident #006, after the resident requested a second staff member to be involved in the care. DOC #114 indicated that in the video, PSW #127 was noted to be speaking to another PSW working that shift and could have gotten that PSW to assist with the resident's care but did not do so.

DOC #114 confirmed the licensee failed to ensure that written plan of care set out for resident #006 was being provided, when PSW #127 provided care to resident #006 without assistance. The plan of care indicated that two staff assistance were required to provide care to resident #006. (760) [s. 6. (7)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that resident #008 was dressed appropriately, in their own clean clothing.

The MLTC received a complaint from the family member of resident #008 related to various areas of their care including concerns that resident #008 was found by their family members wearing stained clothing.

A record review of resident #008's progress notes indicated RPN #133 documented that a PSW reported to them that resident #008 was wearing stained clothing. Resident #008 was changed shortly after it was brought to the staff's attention.

An interview with RPN #133 indicated that they were approached by a PSW at around the start of their shift and saw resident #008 wearing stained clothing. The family member spoke with the PSW and indicated the stain was acquired from the previous shift. RPN #133 confirmed that resident #008 was not dressed in a presentable manner and was not cleaned before the end of the previous shift.

DOC #114 indicated in an interview that the home's expectation would be for staff to clean the resident and ensure if there were stains on their clothing, the staff should have changed their clothing. DOC #114 confirmed the home failed to ensure that resident #008 was dressed appropriately and was wearing clean clothing.

The licensee failed to ensure that resident #008 was dressed appropriately and in clean clothing. (760) [s. 40.]

Issued on this 5th day of June, 2020

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 27, 2020	2020_598570_0005	006273-20, 009206-20, 009212-20, 009757-20	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 20, 21, 22, 25 - 29, 31, June 1 - 5, 7 - 12, 14 - 19, 21 - 26, 29, 2020.

The following Critical Incident Report (CIR) intakes were inspected upon during this Critical Incident System (CIS) Inspection:
A log #009212-20, related to a reportable incident.
Three logs #006273-20, #009206-20 and #009757-20 related to falls incidents.

PLEASE NOTE:
- Written Notifications and Compliance Orders (CO) related to LTCHA, 2007, c.8, s. 6. (4) (b) and s. 90. (2) (a) were identified in this inspection and have been issued in Inspection Report #2020_598570_0006, dated July 27, 2020.
- Written Notifications and Voluntary Plans of Correction (VPC) related to LTCHA, 2007, c.8, s. 6. (7), s. 8. (1) (b), s. 49. (2) and s. 52. (2) were identified in this inspection and have been issued in Inspection Report #2020_598570_0006, dated July 27, 2020.
- Written Notifications related to LTCHA, 2007, c.8, s. 38. (a), s. 89. (1) (a) (i) and s. 107. (4) 2. ii were identified in this inspection and have been issued in Inspection Report #2020_598570_0006, dated July 27, 2020.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Senior Executive Director (SED), Director of Care (DOC), Assistant Directors of Care (ADOC), Medical Doctors (MD), Registered Dietitians (RD), RAI-MDS coordinator, Clinical Consultant (CC), Food Service Manager (FSM), Environmental Services Supervisor (ESS), Infection Control Practitioner (ICP), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Personal Support Workers (PSW), Family members and residents.

During the course of the inspection, the inspector(s) toured residents' home areas, conducted observations, reviewed clinical records and reviewed relevant policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the written plan of care for each resident, sets out the planned care for the resident.

A Critical Incident Report (CIR) was submitted to the Director regarding a fall incident involving resident #008. The CIR indicated that the resident was transferred to hospital and was diagnosed with an injury.

A review of clinical records for resident #008 indicated that the resident was at risk for falls.

A review of progress notes for resident #008 indicated that specified interventions were utilized for falls prevention.

A review of resident #008's written plan of care indicated that the specified interventions for falls prevention were not included in the written plan of care, until after the resident sustained a fall with an injury.

During separate interviews, PSW #137 and RN #146 indicated that resident #008 had interventions for falls prevention in place prior to the fall that resulted in an injury.

During separate interviews with the DOC, ADOC #145 and the RAI MDS Coordinator, they acknowledged that the use of specified interventions for falls prevention were not included in the written plan of care for resident #008, until after the resident sustained a fall with an injury.

The licensee did not ensure that the written plan of care for resident #008 set out the planned care for the resident, specific to falls prevention interventions. [s. 6. (1) (a)] (570)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care for each resident, sets out the planned care for the resident, to be implemented voluntarily.

Issued on this 30th day of July, 2020

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 27, 2020	2020_598570_0006	006667-20, 006692-20, 007614-20, 007617-20, 007855-20, 009090-20, 009895-20, 010038-20, 010428-20, 010487-20, 014324-20	Complaint

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SAMI JAROUR (570), MOSES NEELAM (762)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 20, 21, 22, 25 - 29, 31, June 1 - 5, 7 - 12, 14 - 19, 21 - 26, 29, 2020.

The following intakes were inspected upon during this Complaint Inspection:
A log #010038-20 related to care concerns.
A log #009090-20 related to a fall incident.
A log #007617-20 related to nutrition and hydration and care concerns.
A log #009895-20 related to infection control program and care concerns.
A log #010487-20 related to care concerns.
A log #007855-20 related to a fall incident and care concerns.
A log #007614-20 related to dining and snack services.
A log #006667-20 related to nutrition and hydration program.
A log #006692-20 related to care concerns.
A log #014324-20 related to a reportable incident.
A log #010428-20 related to the Canadian Armed Forces (CAF) report on observations in Long-Term Care Homes (LTCH) regarding concerns with: infection control, standards of practice and quality of care, supplies, ambiguity of local practices, communications and staffing.

PLEASE NOTE:
- Written Notifications and Compliance Orders (CO) related to LTCHA, 2007, c.8, s. 6. (4) (b) and s. 90. (2) (a), identified in a concurrent CIS inspection #2020_598570_0005 were issued in this report.
- Written Notifications and Voluntary Plans of Correction (VPC) related to LTCHA, 2007, c.8, s. 6. (7), s. 8. (1) (b), s. 49. (2) and s. 52. (2), identified in a concurrent CIS inspection #2020_598570_0005 were issued in this report.
- Written Notifications related to LTCHA, 2007, c.8, s. 38. (a), s. 89. (1) (a) (i) and s. 107. (4) 2. ii, identified in a concurrent CIS inspection #2020_598570_0005 were issued in this report.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Senior Executive Director (SED), Director of Care (DOC), Assistant Directors of Care (ADOC), Medical Doctors (MD), Registered Dietitians (RD), RAI-MDS coordinator, Clinical Consultant (CC), Food Service Manager (FSM), Environmental Services Supervisor (ESS), Infection Control Practitioner (ICP), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Personal Support Workers (PSW), Family members and residents.

During the course of the inspection, the inspector(s) toured residents' home areas, conducted observations, reviewed clinical records and reviewed relevant policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Skin and Wound Care
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **9 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

A Critical Incident Report (CIR) was submitted to the Director regarding a reportable incident. A related complaint was submitted to the Ministry of Long-Term Care (MLTC).

A review of clinical records including the written plan of care and electronic Medication Administration Record (eMAR) for resident #001 indicated the resident was at a nutritional risk and required a specified intervention including a nutritional supplement.

A review of resident #001's plan of care, directed staff to report any problems with nutritional intake to physician and dietitian.

A review of progress notes for resident #001 indicated, on a specified date, RPN #117 documented that resident #001 had difficulty with nutritional intake and had an identified symptom. On same date, RN #118 documented resident #001 did not tolerate the nutritional supplement well. At a later date, RN #118 documented that resident #001 had difficulty tolerating the nutritional supplement.

During an interview, PSW #104 indicated that RPN #101 asked that if they could give the nutritional supplement to resident #001. The PSW indicated they reported to RPN #101

that resident #001 did not like the supplement and that the resident might not be able to tolerate it. The PSW indicated that the RPN was notified when the incident occurred.

During an interview, registered dietitian (RD) #109 indicated that they were not aware of any concerns of nutritional intake and identified symptoms involving resident #001 as noted in the progress notes. The RD indicated that no referral was submitted for the resident for those concerns.

During an interview, the nursing supervisor RN #113 indicated, upon review of the progress notes for resident #001, no awareness that resident #001 had concerns with nutritional intake and identified symptoms. The RN indicated that registered staff should have notified the physician and send a referral to the dietitian.

During an interview, the Medical Doctor (MD) #119, indicated no awareness that resident #001 had any difficulty tolerating the nutritional intake or resident`s condition as it was not reported or documented in their communication book.

During an interview, the Director of Care (DOC) #125 indicated, upon review of progress notes for resident #001, that both the physician and dietitian should be notified of any incidents of not tolerating nutritional intake. DOC #125, further indicated that it was the responsibility of registered nursing staff to administer the nutritional supplement when ordered in the eMARs to be administered at medication pass.

The licensee has failed to ensure that staff and others involved in the different aspects of care of resident #001 collaborated with each other, in the development and implementation of the plan of care. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the care set out in resident #009’s plan of care was provided to the resident as specified in the plan.

A CIR was submitted to the Director, regarding a fall incident involving resident #009. The CIR indicated the resident was transferred to hospital and diagnosed with an injury.

A review of resident #009’s written plan of care indicated the resident was at risk for falls. The plan of care directed specified interventions for falls prevention and to minimize falls related injuries.

During separate interviews, PSW #142 and RPN #147 indicated when resident #009 fell,

the resident did not have specified falls prevention interventions in place.

During an interview, DOC #125 indicated that resident #009's plan of care was not followed when the resident did not have specified interventions in place.

The licensee has failed to ensure that the care set out in the plan of care is provided to resident #009 as specified in the plan, specific to falls prevention interventions. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in resident #010's plan of care was provided to the resident as specified in the plan.

A CIR was submitted to the Director, regarding a fall incident involving resident #010. The CIR indicated the resident was transferred to hospital and diagnosed with an injury

A review of the CIR documentation indicated a specified falls prevention intervention in place.

A review of resident #010's written plan of care indicated the resident was at risk for falls and required a specified intervention for falls prevention.

During observations of resident #010's room on two separate dates, the specified intervention for falls prevention was not in place.

During separate interviews PSW #141, RPN #111 and RPN 151, they confirmed upon observations that the resident did not have a specified falls prevention intervention in place.

During an interview, ADOC #145 indicated residents at risk for falls would be identified in the care plan and would have a specified intervention in place. ADOC #145 indicated the written plan of care was not followed as a specified falls prevention intervention for resident #010 was not in place.

The licensee has failed to ensure that the care set out in the plan of care is provided to resident #010 as specified in the plan, specific to falls prevention interventions. [s. 6. (7)] (570)

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum.

A CIR was submitted to the Director regarding a reportable incident. A related complaint was submitted to the MLTC.

A review of the CIR indicated registered staff were unable to get a medical device to work when attempted to use for resident #001.

A review of email communication from RN #123 to the DOC and RN #113, indicated that a medical device located in a specified resident home area had no power cord and could not be used.

During an interview, RPN #101 indicated that they could not get the medical device to work, when needed to be used.

During an interview, RPN #102 indicated no awareness if a specified medical device was available on the resident home area where resident #001 resided. The RPN was able to locate the medical device stored in the medication room. The RPN acknowledged that the device was broken and that they would notify a supervisor.

During an interview, RPN #103 indicated that specified medical devices were to be checked by night staff weekly and any concerns would be forwarded to the night supervisor and the infection control nurse. The RPN indicated there was a check list to be completed but that check list had not been used. The RPN further indicated that a medical device on a specified resident home area was checked by a military personal and found that the device did not have enough power to operate.

During an interview, RN supervisor #113 indicated that a month prior to the COVID-19 outbreak, the medical device in a specified resident home area was checked and was not in working condition and that the DOC was informed.

During an interview, DOC #125 indicated that they were aware the medical device on a specified resident home area was not working and that the device was replaced. The DOC further indicated that the night staff did not complete the weekly checklist consistently after checking the medical device during the night shift.

The licensee has failed to ensure that specified medical devices were kept in a good state of repair. [s. 90. (2) (a)] (570)

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

In accordance with O. Reg 79/10, s. 48 (1) 1. and in reference to O. Reg 79/10 s. 49 (1) the licensee was required to ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home, that provided strategies to monitor residents.

Under O. Reg 79/10. s. 30 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Specifically, staff did not comply with the home’s policy “Falls Prevention and Management Program #RC-15-01-01” last updated December 2019, which required nursing staff to implement the post-fall clinical pathway and provide a focused assessment by the “first registered staff person on the scene” and to reassess for possible injury and pain”. Appendix five of the policy, Post Fall Clinical Pathway (last updated August 2019), indicated that staff were to decide to move the resident using a lifting device (following assessment by nurse and approval for transfer).

A CIR was submitted to the Director, regarding a fall incident involving resident #009.

The CIR indicated the resident was transferred to hospital and was diagnosed with an injury.

A review of clinical records for resident #009, indicated the resident was lifted and placed in bed by three staff.

A review of the plan of care for resident #009 indicated the resident required full mechanical lift for transferring with the assistance of two staff.

During an interview, RPN #147 indicated they lifted the resident off the floor with the help of three staff. The RPN confirmed they did not use a lifting device to transfer the resident to bed.

During an interview, DOC #125 acknowledged that the home's policy "Falls Prevention and Management Program" was not followed when resident #009 was transferred to bed without the use of lifting device.

The licensee has failed to ensure that the home's policy for Falls Prevention and Management Program was complied when resident #009 was lifted off the floor without using a lifting device. [s. 8. (1) (a),s. 8. (1) (b)] (570)

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 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 is complied with, to be implemented voluntarily.

WN #4: 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 resident #010 had fallen, a post-fall assessment was conducted using a clinically appropriate instrument specifically designed for falls.

A CIR was submitted to the Director, regarding a fall incident involving resident #010. The CIR indicated the resident was transferred to hospital and was diagnosed with an injury.

A review of progress notes for resident #010 did not indicate that a post-fall assessment was completed when the resident reported to RPN #150 that they had fallen.

A review of the home's policy "Falls Prevention and Management Program #RC-15-01-01", last updated December 2019, indicated nursing staff to implement the post-fall clinical pathway and complete an initial physical and neurological assessment after a resident has fallen. Appendix five of the policy, Post Fall Clinical Pathway (last updated August 2019), indicated that staff were to provide a focused assessment by the first registered staff person on the scene and to reassess for possible injury and pain.

During an interview, RPN #150 indicated they were directed by RN #113 to assess resident #010 for a skin injury. The RPN confirmed that a post-fall assessment was not completed when the resident reported they had fallen.

During an interview, RN #113 indicated they asked RPN #150 to check what was wrong with resident #010 as the resident was noted to have a skin injury. The RN indicated that a post-fall assessment should have been completed for the resident as the resident reported having a fall to RPN #150, was noted to have a skin injury and was complaining of pain.

During separate interviews, DOC #125 and ADOC #145 confirmed that a post-fall assessment was not completed for resident #010 when the resident reported to RPN #150 that they had fallen.

The licensee has failed to ensure that when resident #010 had fallen, a post-fall assessment was conducted using a clinically appropriate instrument specifically designed for falls. [s. 49. (2)] (570)

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, a post-fall assessment is conducted using a clinically appropriate instrument specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #012 received a skin assessment by a member of registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, when resident #012 exhibited altered skin integrity in relation to falls.

A complaint was made to MLTC indicated that resident #012 had falls with multiple injuries and was transferred to the hospital on the last fall.

A review of resident #012's clinical records indicated that resident #012 had multiple falls and had skin injuries due to falls. A skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment was not completed on two identified dates.

In an interview, RN #131 indicated that resident #012 had altered skin integrity on two identified dates, and a skin assessment using a clinically appropriate assessment instrument was not used in conducting a skin assessment.

In an interview, RN #154 who is the Skin and Wound Lead, indicated the expectation for the staff in the LTCH was to complete a skin assessment when a resident exhibited altered skin integrity. RN #154 indicated that resident #012 had altered skin integrity on two identified dates and a skin assessment using a clinically appropriate assessment instrument was not used in conducting a skin assessment.

The licensee has failed to ensure resident #012 received a skin assessment by a member of registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, when resident #012 exhibited altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure resident #012, was assessed by a Registered Dietician (RD) who is a member of the staff of the home, when resident #012 exhibited altered skin integrity in relation to falls.

A review of resident #012's clinical records indicated that resident #012 had exhibited altered skin integrity.

In an interview, RN #131 indicated that resident #012 had altered skin integrity, and a referral was not made to the RD according to the homes process.

In an interview RD #109, indicated they did not receive any referrals for resident #012 after resident had exhibited altered skin integrity as a result, the RD did not assess the resident.

The licensee has failed to ensure resident #012 was assessed by a RD who is a member of the staff of the home, when resident #012 exhibited altered skin integrity in relation to falls. [s. 50. (2) (b) (iii)] (762)

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A CIR was submitted to the Director, regarding a fall incident involving resident #010. The CIR indicated that the resident reported to RPN #150 of having pain and stated they had fallen. As needed (PRN) pain medication was given to the resident. The resident was transferred to hospital and diagnosed with an injury.

A review of clinical records for resident #010 indicated that RPN #150 recorded resident's pain level and noted that the administration of PRN pain medication was ineffective. The review did not indicate that a pain assessment was completed when the resident complained of pain.

During an interview, RPN #150 indicated they were directed by RN #113 to assess resident #010 for a skin injury. RPN #150 indicated no awareness if resident #010's complaint of pain was a new pain. The RPN indicated that they administered PRN medication for pain which was ineffective, and the resident received another PRN medication for pain. The RPN indicated that a pain assessment should have been completed for the resident.

During an interview, RN #113 indicated when the resident complained of new pain, a pain assessment should have been completed and the resident should have been started on a 72 hrs pain assessment.

During separate interviews, the DOC #125 and the ADOC #145 indicated that the pain assessment should have been completed for resident #010, as the resident was experiencing pain.

The licensee has failed to ensure that when resident #010 complained of new pain that was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument, specifically designed for this purpose. [s. 52. (2)] (570)

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's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to measure and record resident #003's and #011's monthly weight.

A review of resident #003's clinical record conducted indicated that the resident was not weighed in a specified month.

In separate interviews, RPN #127, RD #109 and PSW #128 indicated that resident #003's weight was not taken or recorded in a specified month.

A review of resident #011's clinical record indicated that the resident was not weighed in a specified month.

In an interview, RPN #121 indicated that resident #011's weight was not taken or recorded in a specified month.

In separate interviews, ADOC #145 and DOC #125 indicated that resident #011's weight was not taken or recorded in a specified month.

The licensee has failed to measure and record resident #003's and resident #011's monthly weight. [s. 68. (2) (e) (i)] (762)

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 ensure the implementation of policies and procedures relating to nutrition care and dietary services and hydration including monitoring and recording of weight on admission and monthly thereafter, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (3) Subsection (2) does not apply in the case of emergencies or exceptional and unforeseen circumstances, in which case the training set out in subsection (2) must be provided within one week of when the person begins performing their responsibilities. 2007, c. 8, s. 76. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff have received training within one week of hire.

On March 20, 2020, the Assistant Deputy Minister, Long-Term Care Operations Division of the Ministry of Long-Term Care, issued a memorandum to the sector specific to Amendments to Ontario Regulation 79/10 under the Long-Term Care Homes Act, 2007 related to the COVID-19 Pandemic.

The memorandum and directed the following specific to training:
3. Prioritize the timing of specific training requirements such as Abuse, Infection prevention and Control ensuring those requirements are completed as soon as possible. Training must be provided within one week of the staff member beginning to perform their responsibilities on the following specific topics:
- The Residents' Bill of Rights.
- The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
- The duty under section 24 of the Long-Term Care Homes Act, 2007 to make mandatory reports.
- Fire prevention and safety.
- Emergency and evacuation procedures.
- Infection prevention and control.
All other required training must be provided within three months of the staff member beginning to perform their responsibilities.

During separate interviews, PSW #159, #162, #116, RPN #110 and RPN #147 confirmed that they had no training provided at the LTCH on the above mentioned topics. PSW #116, RPN #110 and RPN #147 indicated they had training on donning and doffing of PPEs and hand hygiene.

During an interview, the DOC #125 confirmed that training was not provided within one week of hire of new staff during the outbreak.

The licensee did not ensure that staff have received training within one week of the staff member beginning to perform their responsibilities. [s. 76. (3)] (570)

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, in case of emergencies or exceptional and unforeseen circumstances, the training set out in subsection (2) must be provided within one week of when the person begins performing their responsibilities, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drugs are administered to a resident in the home unless the drug has been prescribed for the resident.

A review of resident #015's clinical records on Point Click Care (PCC) indicated that the resident was to receive specified medications.

A review of the medication incident report, indicated, resident #015 was given a specified intervention due to an assessment, however, the resident was not prescribed the specified intervention as an option and no separate order was given by the MD.

In an interview, DOC #125 indicated that resident #015 was given a specified intervention, a medication that they were not prescribed.

The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. [s. 131. (1)]

2. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A review of resident #003's clinical records on PCC indicated that the resident was to receive a specified dose of medication at a specified time.

A review of the medication incident report, indicated, resident #003 was given a specified medication at the wrong specified administration time. When RPN #120 was reviewing the medication count, it was noted that the medication for a specified administration time was not given and administered another dose resulting in two doses being given. It was noted by RPN #120 and #121 that two doses of the specified medication were given instead of one.

In an interview RPN #121, indicated when replacing RPN #120 due to an emergency, a medication count was conducted. It was determined, based on the count that resident #003 was given the medication twice. RPN#121 indicated there were no adverse effects as a result of the medication incident.

In an interview DOC#125 indicated that resident #003 was given the medication twice, which resulted in a medication error.

The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)] (762)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

During this inspection, Inspector #570 observed the following:

- PSW #159 was in resident #026's room assisting the resident with their drink. The PSW was wearing a cloth mask and goggles. The sign posted on resident #26's door indicated droplet contact precautions and directed staff to wear full PPE including masks, face shield, gown and gloves. The PSW was not wearing a gown while sitting and feeding the resident.
- PSWs #134 and #160 were observed removing their masks while seated at the nursing station in residents' home area.

During an interview, PSW #159 indicated that they would wear a gown when providing care to the resident. The PSW indicated awareness of the posted sign of droplet/contact precautions on resident #025's door. The PSW acknowledged using their own cloth mask due to sensitive skin to the surgical mask provided by the home and indicated not having a replacement, if the mask was soiled.

During an interview, RPN #110, indicated that all staff should follow instructions on the posted signs when entering residents' rooms.

During separate interviews, both PSW #134 and #160 indicated awareness of the requirement to keep the mask on all the time when on the residents' home area.

During an interview, the senior executive director ED #161 indicated staff are expected to use surgical masks supplied by the LTC home and adhere to infection control practices by wearing full PPE, when assisting residents on droplet precautions in their rooms.

During an interview, DOC #125 indicated that staff removing their masks was not acceptable and was not a good infection control practice.

The licensee failed to ensure staff participated in the implementation of the IPAC program, related to observations made of posted additional precautions signs and PPE and universal masking. [s. 229. (4)] (570)

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 38. Notification re personal belongings, etc.
Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,
(a) the resident's personal aids or equipment are not in good working order or require repair; or
(b) the resident requires new personal belongings. O. Reg. 79/10, s. 38.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident or the resident's substitute decision-maker was notified when, the resident required new personal belongings.

During observations of resident #010's room, a mobility device used by resident #010, equipped with a pressure relieving device. The device's cover was noted to be visibly torn with holes.

A review of progress notes for resident #010 did not reveal any communication with resident's SDM regarding the condition of the pressure relieving device cover.

During separate interviews PSW #141, RPN #111 and RPN 151, all confirmed the condition of the device's cover being torn with holes.

During an interview, ADOC #145 indicated that when staff noticed the device's cover was torn, they should follow up and speak with resident's SDM and speak to the Occupational Therapist to get a replacement.

The licensee failed to ensure the resident's substitute decision-maker was notified when, the pressure relieving device's cover used on resident's mobility device required replacement. [s. 38. (a)] (570)

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #010's linens were changed at least once a week and more often as needed.

During observations of resident #010's room, resident #010's bed linens were noted to be visibly soiled with a brown stain for two consecutive days.

During an interview with resident #010, they indicated that the linens were not changed.

During separate interviews RPN #111 and RPN #151, they confirmed the condition of the soiled linen and indicated the linen should have been replaced.

During an interview, ADOC #145 indicated that the home had plenty of linen supplies and that linens should be replaced when soiled.

The licensee failed to ensure resident #010's linens were changed when the linens were noted to be soiled. [s. 89. (1) (a) (i)] (570)

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(ii) names of any staff members or other persons who were present at or discovered the incident.

A CIR was submitted to the Director, which stated that resident #009 had sustained a fall. The CIR indicated that the resident was transferred to hospital and was diagnosed with an injury. The CIR did not identify all staff members involved in the incident and had transferred the resident off the floor to bed.

During an interview, RPN #147 indicated the resident was found on the floor and was lifted off the floor with the help of three staff. The RPN indicated they did not use a lifting device to transfer the resident to bed.

During an interview DOC #125 could not identify all staff involved in assisting the resident and acknowledged that the names of all staff involved should have been included in the CIR.

The licensee failed to ensure that the report to the Director included the names of any staff members or other persons who were present at or discovered the incident. [s. 107. (4) 2. ii.] (570)

Issued on this 30th day of July, 2020

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SAMI JAROUR (570), MOSES NEELAM (762)
Inspection No. / No de l'inspection :	2020_598570_0006
Log No. / No de registre :	006667-20, 006692-20, 007614-20, 007617-20, 007855-20, 009090-20, 009895-20, 010038-20, 010428-20, 010487-20, 014324-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 27, 2020
Licensee / Titulaire de permis :	CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.) 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 Valley Farm Road, PICKERING, ON, L1V-3R6

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Name of Administrator / Nom de l’administratrice ou de l’administrateur : Jason Gay

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To CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee must be compliant with s. 6 (4) (b) of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee must:

1. Develop and implement a process to ensure all staff involved in providing care to any resident in the home, collaborate with each other in the development and implementation of the plan of care so that the different aspects of care for that resident are integrated and are consistent with and complement each other.

2. Educate all staff on the home's process to ensure collaboration among staff involved in providing care to any resident in the home.

3. Maintain a record of the above-mentioned process and the education provided, including the content, facilitator, attendees, dates, and times. This record shall be made available to the Inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

A Critical Incident Report (CIR) was submitted to the Director regarding a reportable incident. A related complaint was submitted to the Ministry of Long-Term Care (MLTC).

A review of clinical records including the written plan of care and electronic Medication Administration Record (eMAR) for resident #001 indicated the resident was at a nutritional risk and required a specified intervention including a nutritional supplement.

A review of resident #001's plan of care, directed staff to report any problems with nutritional intake to physician and dietitian.

A review of progress notes for resident #001 indicated, on a specified date, RPN #117 documented that resident #001 had difficulty with nutritional intake and had an identified symptom. On same date, RN #118 documented resident #001 did not tolerate the nutritional supplement well. At a later date, RN #118 documented that resident #001 had difficulty tolerating the nutritional supplement.

During an interview, PSW #104 indicated that RPN #101 asked that if they could give the nutritional supplement to resident #001. The PSW indicated they reported to RPN #101 that resident #001 did not like the supplement and that the resident might not be able to tolerate it. The PSW indicated that the RPN was notified when the incident occurred.

During an interview, registered dietitian (RD) #109 indicated that they were not aware of any concerns of nutritional intake and identified symptoms involving resident #001 as noted in the progress notes. The RD indicated that no referral was submitted for the resident for those concerns.

During an interview, the nursing supervisor RN #113 indicated, upon review of the progress notes for resident #001, no awareness that resident #001 had concerns with nutritional intake and identified symptoms. The RN indicated that registered staff should have notified the physician and send a referral to the dietitian.

During an interview, the Medical Doctor (MD) #119, indicated no awareness that resident #001 had any difficulty tolerating the nutritional intake or resident`s condition as it was not reported or documented in their communication book.

During an interview, the Director of Care (DOC) #125 indicated, upon review of progress notes for resident #001, that both the physician and dietitian should be notified of any incidents of not tolerating nutritional intake. DOC #125, further indicated that it was the responsibility of registered nursing staff to administer the nutritional supplement when ordered in the eMARs to be administered at medication pass.

The licensee has failed to ensure that staff and others involved in the different aspects of care of resident #001 collaborated with each other, in the development and implementation of the plan of care.

The severity of this issue was determined to be a level 3 as there was actual harm or actual risk to resident #001. The scope of the issue was isolated at level 1. The home had a level 2 compliance history as they had previous noncompliance with other sections of the LTCHA. (570)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 27, 2020

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 90 (2) (a) of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee must:

1. Prepare an inventory list of all specified medical devices in the home with the locations identified.

2. Ensure all specified medical devices are kept in good repair, maintained and cleaned at a level that meets manufacturer specifications, at a minimum. A record of the schedule of functional checks and cleaning must be kept.

3. Develop and implement an audit process to ensure that all specified medical devices are checked and tested to determine good function, accessible and readily available for use. The auditing process shall include the person(s) responsible for checking specified medical devices and the frequency of the audits. A record of the auditing process must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure that electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum.

A CIR was submitted to the Director regarding a reportable incident. A related complaint was submitted to the MLTC.

A review of the CIR indicated registered staff were unable to get a medical device to work when attempted to use for resident #001.

A review of email communication from RN #123 to the DOC and RN #113, indicated that a medical device located in a specified resident home area had no power cord and could not be used.

During an interview, RPN #101 indicated that they could not get the medical device to work, when needed to be used.

During an interview, RPN #102 indicated no awareness if a specified medical

device was available on the resident home area where resident #001 resided. The RPN was able to locate the medical device stored in the medication room. The RPN acknowledged that the device was broken and that they would notify a supervisor.

During an interview, RPN #103 indicated that specified medical devices were to be checked by night staff weekly and any concerns would be forwarded to the night supervisor and the infection control nurse. The RPN indicated there was a check list to be completed but that check list had not been used. The RPN further indicated that a medical device on a specified resident home area was checked by a military personal and found that the device did not have enough power to operate.

During an interview, RN supervisor #113 indicated that a month prior to the respiratory outbreak, the medical device in a specified resident home area was checked and was not in working condition and that the DOC was informed.

During an interview, DOC #125 indicated that they were aware the medical device on a specified resident home area was not working and that the device was replaced. The DOC further indicated that the night staff did not complete the weekly checklist consistently after checking the medical device during the night shift.

The licensee has failed to ensure that specified medical devices were kept in a good state of repair.

The severity of this issue was determined to be a level 3 as there was actual harm or actual risk to resident #001. The scope of the issue was a pattern at level 2 as two identified home areas did not have functional specified medical devices. The home had a level 2 compliance history as they had previous noncompliance with other sections of the LTCHA. (570)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 27, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of July, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sami Jarour

Service Area Office /
Bureau régional de services : Central East Service Area Office

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 8, 2020	2020_603194_0013	009220-20	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 10, 11, 12, 13, 14, 17, 18 and 19, 2020

Inspection was completed for a log related to allegations of financial abuse.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Environmental Service Supervisor (ESS), Assistant Director of Care (ADOC), Program Manager, Registered Practical Nurse (RPN) and Personal Support Worker (PSW)

Reviewed the internal investigation documentation and clinical health record for the identified resident.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

During the course of this inspection, Non-Compliances were not issued.
- **0 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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.

Issued on this 17th day of September, 2020

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
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Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 8, 2020	2020_603194_0012	007361-20, 010064-20, 012460-20	Complaint

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 10, 11, 12, 13, 14, 17, 18 and 19, 2020

The complaint inspection included three logs related to personal care.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Nursing falls lead, Program Manager, Activation Staff, Environmental Service Supervisor (ESS) and Food Service Manager (FSM).

During the course of the inspection the inspector reviewed, clinical health records of identified residents, Food and Fluid records, Bathing records, Complaints Binders, Relevant policies related to Fall Prevention Management and Complaints and Customer Service. Observed resident rooms and call bell systems.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in different aspects of the care of resident #002 collaborated with each other in the assessment of the resident related to nutrition and hydration so that their assessments were integrated and were consisted.

A complaint letter from the Substitute Decision Maker (SDM) of resident #002 was received by the Director expressing concerns related to hydration and an ongoing medical condition resulting in hospitalization.

Review of the clinical health records indicated Resident #002 was provided two treatments for an ongoing medical condition within a one month period. Resident #002 was transferred and admitted to hospital.

The plan of care for resident #002 related to nutrition and hydration indicated that staff provided total assistance with all meals and nourishment. Resident #002 was to be provided a specified amount of fluid per day.

During review of the food and fluid intake records for resident #002, it was noted that the daily total fluid volumes during the reviewed period were below the goal range.

Interviews with PSW #110, #122, #123, #124, RPN #111, #107 and #118, all indicated that resident #002 required total assistance with all meals and nourishment and that PSW staff were to document food and fluid intakes in Point of Care (POC). PSW staff interviewed indicated that the documentation of the resident's care was not always completed, but that verbal reports related to intake and outputs for resident #002 would have been provided to the registered staff.

During interview with Inspector, RN #119 and DOC explained that the registered nursing staff were responsible for reviewing the food and fluid records. If there were changes in the resident's nutritional and fluid intake volumes an assessment would be initiated and/or dietary referral would be completed.

RN #126 indicated that they did not recall any concerns related to food and fluids for the resident #002. The progress notes for resident #002 indicated that RN #126 documented for a number of shifts, were the food and fluid records were below the goal range. RN #126 indicated that there were no referrals completed and does not recall having to complete any specific assessment for resident #002 related to hydration.

The FSM #125 indicated that the dietary assessment for resident #002 was completed remotely related to COVID. FSM #125 indicated that resident #002 did not have any previous intake concerns and no dietary referrals were completed for the resident. FSM #125 stated that the assessment would have included a review of the resident's intake records. FSM #125 was not aware that the food and fluid intake records were incomplete for resident #002 for the reviewed period, stating that the progress notes were reviewed, but no staff interviewed.

The licensee failed to ensure that registered staff and FSM collaborated with each other related to resident #002's nutritional and hydration status during the reviewed period. The food and fluid intake records were incomplete, FSM assessment indicated no change in condition when the resident had change in treatment for an ongoing medical condition.

An existing order was issued for this area of non compliance on July 27, 2020 Inspection #2020_598570_0006 with a compliance date of October 27, 2020. [s. 6. (4) (a)]

2. The licensee failed to ensure that the plan of care for resident #001 related to falls was provided as specified.

A complaint from SDM of resident #001 was received by the Director expressing concerns related to falls.

The clinical health record indicated resident #001 had numerous falls during the reviewed period. Post fall assessments for resident #001 were completed and the cause for falls were identified.

The plan of care for falls for resident #001 was reviewed and indicated that staff were to ensure that the call bell and commonly used items were within easy reach.

During interviews, PSW #110, #112, #113, RPN #108 and ADOC #102 have described Resident #001 as being able to stand unassisted but was not safe to transfer unassisted and did not recognize their limitations. RPN #120 was not available for interview.

Review of resident #001's progress notes indicated the following;

On a specific, date the progress notes and post fall assessment stated that resident #001 was reaching for their phone when they fell. The post fall assessment completed by RPN #120 indicated that the fall could have been prevented if the phone was within the resident's reach.

-On another date, the progress notes and post fall assessment stated that resident #001 was reaching to pick up the TV remote, at the time of the fall. During interview RPN #111 stated they had completed the post fall assessment and that during the post fall huddle, staff would have been reminded to ensure that personal items were within the residents reach.

-On another date, the progress notes and post fall assessment stated that resident #001 was trying to reach for the phone when they fell. RPN #118 completed the post fall assessment and indicated that strategies to prevent to fall included to ensure resident had all items required within reach.

The licensee failed to ensure that resident #001's plan of care related to falls was provided as specified when the residents items were not within easy reach or access

resulting in falls. [s. 6. (7)]

3. The licensee failed to ensure that when the resident #001 was reassessed for falls the resident's plan of care was revised, when the resident's care needs changed.

A complaint from SDM of resident #001 was received by the Director expressing concerns related to falls. The SDM indicated that resident #001 had numerous falls at the home.

During interviews PSW #110, #112, #113, RPN #108 and ADOC #102 described Resident #001 as being able to stand unassisted but was not safe to transfer unassisted and did not recognize their limitations.

The clinical health record indicated resident #001 had numerous falls during the reviewed period. Post fall assessment were completed where strategies were identified for resident #001 to prevent further potential falls, but plan of care was not updated and strategies were not implemented.

Review of the post fall assessment indicated that the resident sustained four falls, on separate occasions with strategies identified by registered staff.

During separate interview by Inspector #194 with RPN #107, #114 and #119, all indicated that interventions identified in the post fall assessments were not documented or implemented in the resident's plan of care.

Review of the plan of care for resident #001 was completed by Inspector #194. The strategies identified in the fall assessments were not noted in the plans of care reviewed. The plan of care identified that one of the fall strategies was initiated for resident #001 one month after being assessed.

The licensee failed to ensure that when resident #001 was reassessed for falls the resident's plan of care was revised, when the resident's care needs changed. [s. 6. (10) (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 by ensuring that resident's plan of care are provided as specified and when revised are update related to falls, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written complaint received from the Substitute Decision Maker (SDM) of resident #001 was investigated and resolved within 10 business days.

The SDM of resident #001 express their concerns related difficulty to reach the home on an identified date. The complaint further expressed concerns related to manner in which staff provided information to the SDM and concerns related to safety of resident #001's personal belongings.

The SDM complaint was forwarded to MLTC by the interim ED.

The ED indicated that communication had been forward to the SDM by the Corporate office. The communication spoke to only one of the concerns expressed by the SDM. The ED verified that no further investigation into the concerns had been carried out by the home and the complaint did not receive any further communication from the home related to the identified complaint. [s. 101. (1) 1.]

Issued on this 17th day of September, 2020

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 28, 2020	2020_603194_0015	011886-20, 012153-20, 015655-20	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 21, 22, 23, 24, 25, 28, 29, 30, October 1, 5, 2020. October 6 and 7, 2020 were offsite.

Inspector completed:
Follow up inspection related to Order under O. Reg 79/10 s.90(2) with compliance date of August 27, 2020.
Critical Incident related to fall of a resident
Critical Incident for allegations of staff to resident abuse

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN) and residents.

The inspector observed staff to resident interaction. The review of clinical health records of identified residents, abuse investigation notes, fall assessment records, relevant policy related to PASD's were completed.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 90. (2)	CO #002	2020_598570_0006	194

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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 failed to ensure that the Director was informed of the outcome of the abuse investigation.

A Critical Incident Report (CIR) was submitted to the Director for allegations of abuse of a resident a by PSW.

The resident reported to the RPN that two weeks prior a PSW had been abusive during care. The RN completed an assessment with no findings. The resident was interviewed by Inspector and was able to recall the incident, verifying information provided in the CIR. Review of the internal investigation was completed, where PSW denied the allegation of abuse. The Administrator stated the outcome of the internal investigation which was unfounded. The Director was not notified of the outcome of the abuse involving resident.

Sources: Internal abuse investigation notes, CIR, resident progress notes, interviews with ADOC, Administrator and other staff. [s. 23. (2)]

Issued on this 29th day of October, 2020

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 28, 2020	2020_603194_0016	007304-20, 017850-20, 018174-20, 020238-20	Complaint

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 21, 22, 23, 24, 25, 28, 29, 30, October 1, 5, 2020. October 6 and 7, 2020 were completed offsite.

Inspected a Complaint related to resident care, a Complaint related to menu, call bells and flooring, a Complaint and a Critical Incident Report related to disease management.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW), Food Service Manager (FSM), Infection Control Practitioner (ICP), Housekeeping staff, Environmental Service Manager (ESM), Dietary Aide, Corporate Representative, Physician and Residents.

The inspector observed staff to resident provision of care, condition of flooring throughout the home, infection control practices and call bells. The inspector reviewed, clinical health records of identified residents, COVID-19 screening records, relevant policies related to infection control practices, Medication policy, cleaning of floors and Complaints and customer service.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1.The licensee failed to ensure that the staff and others involved in the different aspects of the resident's care, collaborated with each other in the development and implementation of the plan of care, so that the different aspects of care were integrated and were consistent with and complement each other.

The resident stated that they do not recall anyone speaking to them about management of their condition during their admission, where a number of treatments were discontinued. The resident had asked the registered staff and physician on numerous occasions since admission to have the treatments re-ordered. Registered staff and physician did not collaborate with each other related to the re-ordering of the resident's treatments, placing the resident at an increased risk of harm. The resident was subsequently admitted to hospital for assessment.

Sources: The resident's electronic Medication Administration Record (e-MARs), record of therapeutic testing records, Progress notes, the Medication policy, Interview with resident, Registered staff and others. [s. 6. (4) (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 by ensuring that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care, so that the different aspects of care were integrated and were consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint received from a resident's SDM, was immediately forwarded to the Director.

A written complaint was provided to the DOC describing ongoing resident care concerns. The DOC stated that the concerns related to the resident were addressed but were not forwarded to the Director.

Sources: Clinical health record of the resident, complaint letter, Investigation notes, Complaint and Customer service Policy, Interview with DOC and other staff. [s. 22. (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 by ensuring that a written complaint concerning the care of a resident shall immediately be forwarded to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for cleaning of the common areas, including floors.

A complaint was received by the Director that their hallway flooring was not being cleaned. Observation of the unit verified that soiled areas were visible throughout the hallway.

Policy Cleaning Frequency stated that the home must have a cleaning schedule, and all corridors were to be cleaned routinely, Dust mop and wash hard floor surfaces according to the schedule or use auto-scrubber where available.

Interviews with PSW and RN staff indicated that the hallway flooring on the units were frequently soiled. Several housekeeping staff interviewed were inconsistent in who was responsible for cleaning the hallway flooring on the units. The ESM sated that there were no schedules in place for the cleaning of the hallway flooring on the unit.

Sources: Policy related to cleaning of corridors in the home, review of the housekeeping cleaning checklist, Interviews with ESM, housekeeping, an other staff. [s. 87. (2) (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 by ensuring that procedures are developed and implemented for (ii) common areas and staff areas, including floors, carpets furnishings, contact surfaces and wall surfaces, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a response was made to the SDM of a resident, indicating what the licensee had done to resolve the complaints received.

The SDM of a resident expressed concern in two complaints. Review of the homes internal investigations did not support any evidence, that responses indicating what was done to resolve the two complaints, were provided to the SDM. The DOC stated that responses as to what was done to resolve the complaints were not provided to the SDM of the resident.

Sources: Clinical health record of a resident, complaint letter, Investigation notes, Complaint and Customer service Policy, Interview with DOC and other staff. [s. 101. (1) 3.]

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 by ensuring that every written or verbal complaint made to the licensee concerning the care of a resident or operation of the home is, investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program when personal belongings for a resident, identified with a condition, were washed and hung in a shared bathroom.

SDM of a resident, expressed concern related to soiled items left in the resident's shared bathroom. Review of the co-resident's plan of care indicated that the resident's items were to be washed by the PSW when they became soiled. RPN and PSW explained that PSW staff cleaned the personal items in the shared bathroom sink. Infection Control and Prevention nurse reviewed the cleaning process in place for co-residents personal items and stated that this was not a safe practice.

The home's infection control policy directed to staff were to transport laundry from the resident's room to the laundry room separately from other laundry in the home.

Sources: Infection control policy, clinical health records of a resident, interviews with ICP nurse and others. [s. 229. (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 by ensuring that staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 29th day of October, 2020

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 2, 2020	2020_598570_0013	015654-20, 017646-20, 018136-20	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road Pickering ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 3, 9, 10, 12, 13, 16, 2020.

The following intakes were inspected during this Critical Incident System (CIS) inspection:

- A log related to follow up to CO #001 issued on July 27, 2020, within inspection report #2020_598570_0006, related to LTCHA, 2007 S.O. 2007, c.8, s. 6. (4).
- Two logs related to allegations of abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Infection Prevention and Control Specialist, Programs Manager and Residents.

During the course of the inspection, the inspector observed the provision of care, resident to resident interactions, staff to residents interactions and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #001	2020_598570_0006	570

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment for its residents related to the failure to screen visitors as specified in Directive #3 regarding screening and number of visitors allowed at a time.

Precautions were implemented for resident #005 as the resident was in close contact with more than two visitors at a time including a visitor who was not screened.

The Chief Medical Officer of Health (CMOH) implemented Directive #3 which has been issued to long-term care homes and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in long-term care homes. As per the version of Directive #3 with effective date of implementation on October 16, 2020, long-term care homes must immediately implement active screening of all staff, visitors and anyone else entering the home for COVID-19 with the exception of first responders, who should, in emergency situations, be permitted entry without screening. The Directive further directed that residents are permitted up to a maximum of two visitors at a time.

The Director of Care (DOC) acknowledged the incident when resident #005 had more than two visitors at a time and that one of the visitors was not screened.

The lack of adherence to Directive #3 related to the number of visitors allowed at a time and the lack of adherence to screen all visitors presented an actual risk to residents.

Sources: Directive #3 (version effective date October 16, 2020), screening records, progress notes for resident #005, and interviews with the DOC and others. [s. 5.]

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 is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #002, #003 and #004 were protected from abuse by resident #001.

For the purposes of the Act and Regulation:
Physical abuse is defined as:
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident

The Ministry of Long-Term Care (MLTC) received two critical incident system (CIS) reports related to allegations of abuse by resident #001 toward residents #002, #003, and #004.

Progress notes for residents #001, #002, #003 and #004 and CIS reports submitted to the MLTC for incidents related to resident #001 indicated that residents #002, #003 and #004 sustained visible injuries by resident #001.

The plan of care for resident #001 identified that the resident had responsive behaviours

and directed staff to look for signs that resident might be getting agitated and to keep co-residents away from resident #001.

The progress notes for resident #001 were reviewed and indicated an intervention was implemented following the incident involving residents #002 and #003. The progress notes did not indicate that the intervention was implemented to resident #001 at the time of incident involving resident #004.

Interviews conducted with RPN #103 and PSW #104 indicated that resident #001's behaviours can be unpredictable and that the resident had not shown any triggers for the incident involving resident #002 and #003.

Interviews conducted with the Director of Care (DOC) and the Assistance Director of Care (ADOC) verified that resident #001 did not have the specified intervention at the time of the incident involving resident #004.

Residents #002, #003, and #004 were not protected from abuse by resident #001.

Sources: Critical Incident System (CIS) reports, clinical records for residents #001, #002, #003 and #004, interviews with the DOC, ADOC, RPN #103, PSW #104 and others. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: 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 strategies for dealing with resident #001's responsive behaviours were implemented.

The Ministry of Long-Term Care (MLTC) received critical incident system (CIS) report related to allegations of abuse by resident #001 toward resident #004.

The CIS report and progress notes for residents #001 and #004 indicated that resident #004 sustained an injury caused by resident #001.

The plan of care for resident #001 identified that the resident had responsive behaviours directed staff to look for signs that resident #001 might be getting agitated and to keep co-residents away from the resident.

The progress notes for resident #001 were reviewed and indicated the specified intervention was implemented following incident involving residents #002 and #003. The progress notes did not indicate that the interventions was implemented for resident #001 at the time of the incident involving resident #004.

Interviews conducted with the Director of Care (DOC) and the Assistance Director of Care (ADOC) verified that resident #001 did not have the specified intervention at the time of the incident involving resident #004.

Resident #004 sustained an injury and other residents were at risk of harm when a specified intervention was not implemented to manage resident #001's responsive behaviours.

Sources: Critical Incident System (CIS) report, clinical records for residents #001 and #004, interviews with the DOC, ADOC, RPN #103, PSW #104 and others. [s. 53. (4) (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 strategies are developed and implemented for each resident demonstrating responsive behaviours, to be implemented voluntarily.

Issued on this 4th day of December, 2020

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 27, 2021	2020_784762_0026	017034-20, 018848-20, 019946-20, 026112-20	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road Pickering ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MOSES NEELAM (762)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 9-11, 14-18, 22-23, 29-31, 2020 and January 6-7, 2021

The following intakes were inspected during this Critical Incident System (CIS) Inspection:
Logs #017034-20/CIS #2693-000022-20, #018848-20/CIS #2693-000026-20, #019946-20/CIS #2693-000029-20, related to incidents that led to injuries for which the residents were transferred to the hospital.
Log #026112-20/CIS #2693-000037-20, related to an incident that led to an injury for which the resident was transferred to the hospital and had a significant change.

PLEASE NOTE:
- A Written Notification and Compliance Order (CO) related to LTCHA, 2007, c.8, s. 6. (7) was identified in this inspection and has been issued in Inspection Report #2020_814501_0016, dated January 27, 2021

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Family members and residents.

During the course of the inspection, the inspector(s) toured residents home areas, conducted observations, reviewed clinical records and reviewed relevant policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 was safely transferred.

Resident #002 had had an incident when being transferred that led to a fall, RPN #104 and PSW #102, proceeded to lift the resident manually from the floor. DOC #100 indicated that it was determined to be unsafe, as per the home's Post fall clinical pathway- Appendix 5 policy. This put the resident at potential risk for actual injury during the transfer.

Sources: The LTCH investigative notes; The LTCH discipline letters; Post fall clinical Pathway- Appendix 5- policy number RC-15-01-01 A5; Progress notes; Interviews with RPN #104 and PSW #102 [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 3rd day of February, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 27, 2021	2020_814501_0016	013808-20, 014176-20, 015268-20, 015953-20, 016788-20, 017058-20, 017132-20, 019355-20, 019647-20	Complaint

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road Pickering ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SUSAN SEMEREDY (501), MOSES NEELAM (762)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 29, 30, 31, 2020 and January 4, 5, 6, 7, 2021.

The following intakes were inspected in this complaint inspection:
#013808-20 and #017058-20 related to nutrition and hydration, personal support services and reporting and complaints;
#014176-20, #019647-20 #017132-20 related to sufficient staffing;
015268-20 and #016788-20 related to abuse and neglect;
015953-20 related to admission and discharge; and
019355-20 related to safe transferring.

NOTE: A Written Notification and Compliance Order related to LTCHA, s. 6(7) was identified in a concurrent inspection #2020_784762_0026 (Log #026112-20) and issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOCs), Food and Nutrition Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), substitute decision-makers, family members and residents.

During the course of the inspection, the inspectors observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 and #007 during an outbreak in the home.

The Long-Term Care Home (LTCH) was in an outbreak and for the initial two weeks the home had staffing shortages. According to the home's staffing levels, one of the units was to have one RPN and 4 PSWs for both the day and evening shifts. Review of the actual staffing levels indicated that there was on average one RPN and 2 PSWs for both day and evening shifts.

According to regular day staff working on the above noted unit, there was not enough time to provide care and services to all residents. The evening staff consisted mostly of newly hired temporary staff and the regular staff indicated evening shifts often had less staff. As a result, the day staff would not get all residents out of bed because they knew the evening staff could not manage to get them back to bed.

As a result of this staffing shortage, basic care including bathing/showering (including bed baths), oral hygiene, nail care, assistance with eating and drinking and fall prevention monitoring was not provided.

According to resident #007's plan of care, the resident was to be provided a type of hygiene care twice a week. Documentation and interviews indicated the resident was not provided this for over a week as the staff did not have time.

Failing to provide resident #007 with the care and services consistent with their plan of care put the resident at risk of poor hygiene and decreased comfort and dignity.

Sources: Resident #007's written care plan and documentation survey report and interviews with staff. [s. 6. (7)]

2. During the outbreak resident #007 was not provided assistance with eating and drinking adequate food and fluids as required by the plan of care. This contributed towards weight loss.

Failing to provide assistance with eating and drinking put resident #007 at risk for weight loss and dehydration.

Sources: Point of Care documentation by PSWs, clinical assessments, care plan and staff interviews [s. 6. (7)]

3. Resident #005 was known to wander and be at high risk for falls. The plan of care

indicated the resident was to be checked for safety and be reminded to use the toilet.

During the outbreak, the resident had two falls when the unit was short staffed. Staff indicated they were unable to provide resident #005 with monitoring and toileting which may have contributed to resident #005's increased falls.

By failing to follow the plan of care, resident #005 was at a high risk for injury from falls.

Sources: Resident #005's care plan, post fall assessments, progress notes and staff interviews. [s. 6. (7)]

4. Resident #005 was to be assisted with hygiene and grooming. Documentation indicated the resident did not receive this assistance consistently during the outbreak. Staff interviews indicated there was not enough time to provide such assistance.

Failing to provide resident #005 with the care and services consistent with their plan of care put the resident at risk of poor hygiene and decreased comfort and dignity.

Sources: Resident #005's care plan, progress notes, physical chart records and staff interviews. [s. 6. (7)]

5. Staff indicated resident #005 needed more assistance with eating and drinking during the outbreak. Records indicated the resident had significant weight loss. Staff indicated resident #005 was encouraged but could not always be assisted to eat and drink due to staffing shortages.

Failing to assist resident #005 with eating and drinking as their level of care increased put them at risk for weight loss and dehydration.

Sources: Resident #005's progress notes, documentation survey report, fluid intake report, and weight reports and staff interviews. [s. 6. (7)]

6. The licensee has failed to ensure that resident #012 was wearing a protective device according to the plan of care.

The resident had a fall that led to a significant change in status. As a result of this fall, many interventions were put in place, including a protective device to be worn at all times. During an observation, it was noted by inspector #762 that the resident was not

wearing this device.

Failing to apply a protective device put the resident at risk for further injury if a fall occurred.

Sources: Observation, care plan and staff interviews. [762] [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #007 was repositioned every two hours or more frequently as required, when the resident was unable to reposition themselves, leading to the worsening and creation of new wounds.

When the home was in outbreak, resident #007 was not repositioned at least every two hours due to the LTCH's staffing shortage. As a result, the resident developed four areas of altered skin integrity.

Failing to reposition resident #007 put the resident at risk for developing wounds.

Sources: Clinical assessments, Point of Care documentation by PSWs and staff interviews. [s. 50. (2) (d)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The license has failed to ensure that an RPN treated resident #004 with courtesy and respect in a way that fully recognized the resident's individuality and respected their dignity.

While providing resident #004 with care, an RPN made a derogatory comment to the resident. The RPN had indicated that this was meant to be a joke, however, acknowledged that it was inappropriate. This remark was considered disrespectful and the RPN was provided with a discipline letter.

This verbal exchange put the resident at risk of diminishing their well-being, dignity and self-worth.

Sources: The LTCH investigative notes and interview with the DOC. [s. 3. (1) 1.]

Issued on this 4th day of February, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	SUSAN SEMEREDY (501), MOSES NEELAM (762)
Inspection No. / No de l’inspection :	2020_814501_0016
Log No. / No de registre :	013808-20, 014176-20, 015268-20, 015953-20, 016788-20, 017058-20, 017132-20, 019355-20, 019647-20
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 27, 2021
Licensee / Titulaire de permis :	CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.) 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, Cambridge, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 Valley Farm Road, Pickering, ON, L1V-3R6
	Jason Gay

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Name of Administrator /
Nom de l’administratrice
ou de l’administrateur :

To CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), you are hereby required to comply with the following order(s) by the date(s) set out below:

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 # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.

The licensee shall ensure that resident #005, #007 and #012 receive the care as set out in their plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 and #007 during an outbreak in the home.

The Long-Term Care Home (LTCH) was in an outbreak and for the initial two weeks the home had staffing shortages. According to the home's staffing levels, one of the units was to have one RPN and 4 PSWs for both the day and evening shifts. Review of the actual staffing levels indicated that there was on average one RPN and 2 PSWs for both day and evening shifts.

According to regular day staff working on the above noted unit, there was not enough time to provide care and services to all residents. The evening staff consisted mostly of newly hired temporary staff and the regular staff indicated evening shifts often had less staff. As a result, the day staff would not get all residents out of bed because they knew the evening staff could not manage to get them back to bed.

As a result of this staffing shortage, basic care including bathing/showering (including bed baths), oral hygiene, nail care, assistance with eating and drinking and fall prevention monitoring was not provided.

According to resident #007's plan of care, the resident was to be provided a type

of hygiene care twice a week. Documentation and interviews indicated the resident was not provided this for over a week as the staff did not have time.

Failing to provide resident #007 with the care and services consistent with their plan of care put the resident at risk of poor hygiene and decreased comfort and dignity.

Sources: Resident #007's written care plan and documentation survey report and interviews with staff. (501)

2. During the outbreak resident #007 was not provided assistance with eating and drinking adequate food and fluids as required by the plan of care. This contributed towards weight loss.

Failing to provide assistance with eating and drinking put resident #007 at risk for weight loss and dehydration.

Sources: Point of Care documentation by PSWs, clinical assessments, care plan and staff interviews. (762)

3. Resident #005 was known to wander and be at high risk for falls. The plan of care indicated the resident was to be checked for safety and be reminded to use the toilet.

During the outbreak, the resident had two falls when the unit was short staffed. Staff indicated they were unable to provide resident #005 with monitoring and toileting which may have contributed to resident #005's increased falls.

By failing to follow the plan of care, resident #005 was at a high risk for injury from falls.

Sources: Resident #005's care plan, post fall assessments, progress notes and staff interviews. (501)

4. Resident #005 was to be assisted with hygiene and grooming. Documentation indicated the resident did not receive this assistance consistently during the outbreak. Staff interviews indicated there was not enough time to provide such

assistance.

Failing to provide resident #005 with the care and services consistent with their plan of care put the resident at risk of poor hygiene and decreased comfort and dignity.

Sources: Resident #005's care plan, progress notes, physical chart records and staff interviews.
(501)

5. Staff indicated resident #005 needed more assistance with eating and drinking during the outbreak. Records indicated the resident had significant weight loss. Staff indicated resident #005 was encouraged but could not always be assisted to eat and drink due to staffing shortages.

Failing to assist resident #005 with eating and drinking as their level of care increased put them at risk for weight loss and dehydration.

Sources: Resident #005's progress notes, documentation survey report, fluid intake report, and weight reports and staff interviews.

Sources: Resident #005's progress notes, documentation survey report, fluid intake report, and weight reports and interview with RPN #112 and other staff.
(501)

6. The licensee has failed to ensure that resident #012 was wearing a protective device according to the plan of care.

The resident had a fall that led to a significant change in status. As a result of this fall, many interventions were put in place, including a protective device to be worn at all times. During an observation, it was noted by inspector #762 that the resident was not wearing this device.

Failing to apply a protective device put the resident at risk for further injury if a fall occurred.

Sources: Observation, care plan and staff interviews.

An order was made by taking the following factors into account:

Severity: Failing to provide resident #005, #007 and #012 with the care set out in the plan of care put them at risk for actual harm.

Scope: The scope of this non-compliance was a pattern because a total of eleven residents were reviewed for three different care areas and there were findings for the plan of care not being provided for a total of six residents.

Compliance History: In the last 36 months, the licensee was found to be noncompliant with LTCHA s.6(7) and five Written Notifications (WNs), four Voluntary Plans of Correction (VPCs) and one Compliance Order (C) were issued to the home.
(501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 22, 2021

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

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

The licensee must compliant with s. 50(2) of the LTCHA.

Specifically, the licensee must:

Develop a plan to ensure residents that are unable to reposition themselves are repositioned at least ever two hours during any type of staffing shortage. This plan must be implemented for resident #007 and any other resident that requires repositioning during such circumstances.

Grounds / Motifs :

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

1. The licensee has failed to ensure that resident #007 was repositioned every two hours or more frequently as required, when the resident was unable to reposition themselves, leading to the worsening and creation of new wounds.

When the home was in outbreak, resident #007 was not repositioned at least every two hours due to the LTCH's staffing shortage. As a result, the resident developed four areas of altered skin integrity.

Failing to reposition resident #007 put the resident at risk for developing wounds.

Sources: Clinical assessments, Point of Care documentation by PSWs and staff interviews.

An order was made by taking the following factors into account:

Severity: There was actual harm to resident #007 as they developed four pressure ulcers due to not being repositioned.

Scope: The scope of this non-compliance was isolated because the repositioning of the resident every two hours was not completed for one of the three residents reviewed during this inspection.

Compliance History: In the last 36 months, the licensee was found to be noncompliant with O.Reg. 79/10 s. 50(2) and two Written Notifications (WNs) and two Voluntary Plans of Correction (VPCs) were issued the home. (762)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 22, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of January, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Semeredy

Service Area Office /
Bureau régional de services : Central East Service Area Office

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 30, 2021	2021_643111_0008	000614-21, 002129-21, 002130-21	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road Pickering ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LYNDA BROWN (111), CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 13 to 16, 2021.

The following inspections were completed concurrently during this inspection:
-Log #002129-21 for a follow up related to compliance order #001 for plan of care.
-Log #002130-21 for a follow up related to compliance order #002 for skin and wound care.
-Log #000614-21 for a critical incident (CIR) related to a fall with an injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping (HSK), Infection Control Practitioner (ICP), Behavioural Support Ontario (BSO) staff and residents.

During the course of the inspection, the inspector(s): toured the home, reviewed resident health records, active screening records, and reviewed Infection, Prevention and Control (IPAC) policies.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 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
O.Reg 79/10 s. 50. (2)	CO #002	2020_814501_0016	111
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2020_814501_0016	111

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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee has failed to ensure that staff implemented the infection, prevention and control program (IPAC) related to isolation precautions and personal protective

equipment (PPE).

The following IPAC concerns were identified on a specified date:
-resident #001, #002 and #004 had specified precaution signage posted on their door, but there was no PPE available for staff use.
-resident #003 had specified precautions signage posted on their door with PPE available and at a specified time, an RPN was observed entering and exiting the resident's room, without completing appropriate donning and doffing of their PPE.
-resident #013 and #014 had specified precautions signage posted on their door with PPE available for staff use and at a specified time, a PSW was observed returning the resident back to their room, without appropriate donning and doffing of PPE and did not complete hand hygiene as required. The PSW was also unaware of why the resident was on precautions. An RPN confirmed that all residents on specified isolation precautions should have had PPE available. Failing to ensure that staff have the appropriate PPE available for use with residents on isolation precautions and staff failing to complete appropriate IPAC practices related to donning and doffing of PPE, places residents and staff at risk for transmission of infections. (#111)

2. The licensee failed to ensure that staff were participating in implementation of the Infection Prevention and Control Program for resident #008 related to donning and doffing of PPE.

Resident #008 returned from the hospital and was placed on isolation precautions for COVID-19, for 14 days and PPE was available for staff use. On a specified day and time, Inspector #194 observed an RPN enter the resident’s room carrying a meal tray, without completing hand hygiene, or donning the required PPE. The RPN then exited the resident’s room without completing appropriate doffing of PPE. Another PSW entered the resident’s room to assist with meal set up, without donning the appropriate PPE and then exited the room without doffing their PPE as required. The RPN confirmed awareness of the resident's isolation precautions but thought they were only for 10 days. The PSW indicated no awareness that resident #008 was still on isolation precautions despite the signage indicating they were. Staff failing to ensure that the appropriate PPE are donned and doffed while assisting the resident and being aware of isolation precaution procedures, places the staff and resident at risk for the transmission of infection.

Sources: observations throughout the home, resident #008’s progress notes, observation of resident #008 during meal service and interviews with staff. (#194)

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home was a safe and secure environment for residents related to not following Directive #3, for active screening for COVID-19.

Review of the visitor active screening for COVID-19 for a specified period, had no documented evidence that a number of visitors had passed the active screening, or had COVID-19 testing completed on a number of dates. A PSW confirmed when they completed the active screening of all visitors, they are required to mark off whether visitors pass or fail the active screening for COVID-19 on the visitor active screening log and based on the results of the rapid antigen COVID-19 testing. The IPAC lead confirmed that staff should be marking off on the active screening of all visitors log whether the visitor passed or failed the COVID-19 testing. Failing to identify that visitors are actively screened for COVID-19 may lead to possible COVID-19 infections into the home. Review of resident active screening for COVID-19 logs for a specified period, indicated that a number of residents did not receive the twice daily active screening for COVID-19 completed on identified dates and units. Review of the staff active screening for COVID-19 logs for a specified period, indicated a number of staff did not complete active screening for COVID-19, at the beginning or the end of their shift as required on a number of dates. Failing to actively screen residents and staff for COVID-19 may lead to possible COVID-19 infections through the home.

Sources: observations of screening, review of , staff and resident active screening logs for COVID-19 and the PanBio COVID-19 results logs, Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 (updated April 7, 2021), Homes Visitor Policy during COVID-19 and interview with staff. (#194 and #111).

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee failed to ensure that clear direction was provided in the plan of care for resident #008 related to Infection, Prevention and Control Practices and wandering behaviour.

Resident #008 returned from hospital and placed in isolation for COVID-19 with specified precautions, for 14 days. During that period, Inspector #194 observed the resident outside of their room, without a mask. An RPN redirected the resident back to their room, without assisting the resident with hand hygiene or donning a mask and indicated the resident was non-compliant with donning of a mask. The RPN also confirmed that the resident had attended the dining room for meals on a number of occasions, while being on isolation precautions. The plan of care did not have any clear direction related to resident #008's responsive behaviours or how to manage those behaviours while the resident was on isolation precautions. Failing to provide clear direction in the plan of care for resident's responsive behaviours while on isolation for COVID-19 precautions, places other residents and staff at increased risk of transmissions of infections.

Source: Resident #008's care plan and progress notes, observation of resident #008, and interview of staff.(#194)

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 there is a written plan of care for each resident that provides clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and O. Reg. 79/10, s. 24 (3).
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

Findings/Faits saillants :

The licensee failed to ensure that the admission care plan for resident #003 set out clear directions to staff and others who provide direct care to resident for a specified medical procedure.

Resident #003 was admitted with a specified medical procedure. Observation of the resident confirmed they used the specified medical procedure with the door left open. The signage on the door indicated the door was to be closed when medical procedure was in use. A number of RPN's confirmed the resident used the specified medical procedure independently and the door should have been closed. The resident's admission care plan indicated the RPN was to assist with application/removal of the medical procedure. There was no clear direction that the resident applied the device independently or that the door was to be closed while in use. Failing to ensure there is clear direction related to the use of a specified medical procedure can lead to improper care provided.

Sources: observation of resident #003, care plan of resident #003 and interview of staff.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

The licensee failed to ensure that resident #008 was provided appropriate equipment, including a table at an appropriate height, to meet the needs of the resident for dining purposes.

Resident #008 returned from hospital on a specified date and placed on isolation precautions for COVID-19 for 14 days, requiring the resident to have their meals in their room. A number of days later, Inspector #194 observed an RPN place the resident's meal on their mobility aid, as there was no over-bed table available and the resident was struggling to access their meal. A number of RPNs confirmed that the resident required an over-bed table to consume their meals and provided the resident with an over bedside table as a result of the inspection. As a result, the resident was not able to consume their meal for a period of time. Failing to provide the resident with an over-bed table for a number of days, at an appropriate height to meet the need of the resident, minimized the resident's ability to comfortably consume their meals.

Source: Observation of resident #008's room, progress notes for resident #008 and interview of staff. (#194).

Issued on this 7th day of May, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), CHANTAL LAFRENIERE (194)
Inspection No. / No de l'inspection :	2021_643111_0008
Log No. / No de registre :	000614-21, 002129-21, 002130-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 30, 2021
Licensee / Titulaire de permis :	CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.) 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, Cambridge, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 Valley Farm Road, Pickering, ON, L1V-3R6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jason Gay

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with O.Reg 79/10, s. 229(4).

Specifically the licensee must do the following:
1. Ensure there is proper PPE available for staff use, for all residents on isolation precautions.
2. Ensure there is proper signage posted at the resident doorway, for any resident with an AGMP in place upon admission or readmission from hospital, according to PH guidelines.
3. Ensure all staff are donning and doffing the appropriate PPE for any residents on isolation precautions and IPAC lead to continue providing on the spot training for those staff who are not compliant and continue to identify the training on the audits completed.

Grounds / Motifs :

1. The licensee has failed to ensure that staff implemented the infection, prevention and control program (IPAC) related to isolation precautions and personal protective equipment (PPE).

The following IPAC concerns were identified on a specified date:
-resident #001, #002 and #004 had specified precaution signage posted on their door, but there was no PPE available for staff use.
-resident #003 had specified precautions signage posted on their door with PPE available and at a specified time, an RPN was observed entering and exiting the resident's room, without completing appropriate donning and doffing of their PPE.
-resident #013 and #014 had specified precautions signage posted on their door with PPE available for staff use and at a specified time, a PSW was observed returning the resident back to their room, without appropriate donning and

doffing of PPE and did not complete hand hygiene as required. The PSW was also unaware of why the resident was on precautions. An RPN confirmed that all residents on specified isolation precautions should have had PPE available. Failing to ensure that staff have the appropriate PPE available for use with residents on isolation precautions and staff failing to complete appropriate IPAC practices related to donning and doffing of PPE, places residents and staff at risk for transmission of infections (#111).

2. The licensee failed to ensure that staff were participating in implementation of the Infection Prevention and Control Program for resident #008 related to donning and doffing of PPE.

Resident #008 returned from the hospital and was placed on isolation precautions for COVID-19, for 14 days and PPE was available for staff use. On a specified day and time, Inspector #194 observed an RPN enter the resident's room carrying a meal tray, without completing hand hygiene, or donning the required PPE. The RPN then exited the resident's room without completing appropriate doffing of PPE.Another PSW entered the resident's room to assist with meal set up, without donning the appropriate PPE and then exited the room without doffing their PPE as required. The RPN confirmed awareness of the resident's isolation precautions but thought they were only for 10 days. The PSW indicated no awareness that resident #008 was still on isolation precautions despite the signage indicating they were. Staff failing to ensure that the appropriate PPE are donned and doffed while assisting the resident and being aware of isolation precaution procedures, places the staff and resident at risk for the transmission of infection (#194).

Sources: observations throughout the home, resident #008's progress notes, observation of resident #008 during meal service and interviews with staff.

An order was made by taking the following factors into account:
-Severity: There was actual risk of harm to the residents because there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.
-Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations on multiple home areas, and the noncompliance has the potential to affect a large number of the LTCH's

residents.

Compliance History: the home has had non-compliance to the same subsection in the past 36 months as follows:
-issued a Voluntary Plan of Correction (VPC) on September 28, 2020 during inspection #2020_603194_0016. A VPC was issued on September 28, 2020 during inspection #2020_598570_0006. A VPC was issued to O.Reg.79/10, s.229(3) on December 3, 2020. A VPC was issued to O.Reg. 79/10, s. 229(5) on January 27, 2020. (111)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 31, 2021

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, s.5.

Specifically, the licensee shall complete the following:
1.Actively screen staff and visitors for COVID-19 as directed with Directive #3.
2.Ensure residents are screened twice daily for acute respiratory illness-COVID-19, as per Directive #3.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment for residents related to not following Directive #3, for active screening for COVID-19.

Review of the visitor active screening for COVID-19 for a specified period, had no documented evidence that a number of visitors had passed the active screening, or had COVID-19 testing completed on a number of dates. A PSW confirmed when they completed the active screening of all visitors, they are required to mark off whether visitors pass or fail the active screening for COVID-19 on the visitor active screening log and based on the results of the rapid antigen COVID-19 testing. The IPAC lead confirmed that staff should be marking off on the active screening of all visitors log whether the visitor passed or failed the COVID-19 testing. Failing to identify that visitors are actively screened for COVID-19 may lead to possible COVID-19 infections into the home. Review of resident active screening for COVID-19 logs for a specified period, indicated that a number of residents did not receive the twice daily active screening for COVID-19 completed on identified dates and units. Review of the staff active screening for COVID-19 logs for a specified period, indicated a number of staff did not complete active screening for COVID-19, at the

beginning or the end of their shift as required on a number of dates. Failing to actively screen residents and staff for COVID-19 may lead to possible COVID-19 infections through the home.

Sources: observations of screening, review of , staff and resident active screening logs for COVID-19 and the PanBio COVID-19 results logs, Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 (updated April 7, 2021), Homes Visitor Policy during COVID-19 and interview with staff. (#194 and #111). (111)

2. An order was made by taking the following factors into account:
-Severity: There was actual risk of harm to the residents because there was potential for possible transmission of infectious agents due to staff, visitors and residents not having active COVID-19 screening completed, as per Directive #3.

-Scope: The scope of this non-compliance was widespread because the active screening was not being completed with staff, residents and visitors as per the Directive.and the noncompliance has the potential to affect all residents within the LTCH.
-Compliance History: the home has had non-compliance to the same subsection in the past 36 months as follows:issued a Voluntary Plan of Correction (VPC) on December 2, 2020 during inspection #2020_598570_0013. (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 30th day of April, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Central East Service Area Office

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 29, 2021	2021_882760_0022	007419-21, 007421-21, 007713-21	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road Pickering ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JACK SHI (760), SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 22, 23, 24, 25, 2021.

The following intakes were completed in this critical incident inspection:

A log related to a fall;
A follow up log to Compliance Order (CO) #001, O. Reg 79/10 s. 229 (4), related to infection prevention and control, issued under inspection #2021_643111_0008, on April 30, 2021, with a compliance date of May 31, 2021;
A follow up log to Compliance Order (CO) #002, LTCHA s. 5, related to safe and secure home, issued under inspection #2021_643111_0008, on April 30, 2021, with a compliance date of May 31, 2021.

During the course of the inspection, the inspector(s) spoke with Infection Control and Control (IPAC) Specialist, contractors, Dietary Aides, the Social Worker, housekeepers, Food service and Nutrition Manager, visitors, residents, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and the Director of Care (DOC).

During the course of the inspection, the inspectors observed resident and staff interactions, the provision of care and infection prevention and control practices. Inspectors also reviewed clinical health records, relevant home policies and procedures, temperature monitoring logs other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #002	2021_643111_0008	760

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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. Compliance Order (CO) #001 related to O. Reg. 79/10, s. 229 (4) from Inspection #2021_643111_0008 issued on April 30, 2021, with a compliance due date of May 31,

2021, is being re-issued as follows:

The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

A follow-up inspection was conducted, and the staff along with visitors and contractors continued to be noncompliant with the implementation of the home's IPAC program.

Observations were carried throughout the home during this inspection:
- A PSW was observed to be talking to a resident and was not wearing any eye protection. The IPAC specialist stated the PSW should have worn eye protection.
- A visitor was observed without wearing a mask while they were with a resident. The IPAC specialist stated that the visitor was supposed to wear a surgical mask when they were with the resident.
- A PSW was observed applying two pairs of gloves prior to entering a resident room. The IPAC specialist stated that it is not part of the home’s practice to put two pairs of gloves on.
- A contractor was observed going in and out of a resident room on precautions without wearing the appropriate personal protective equipment (PPE). The contractor was later seen wearing the same gown while entering several different resident rooms.
- A dietary aide (DA) was observed with their soiled gloves on while they entered a hallway area. The IPAC specialist stated that the DA should have doffed their gloves after finishing their task and should not have kept it on while they entered the hallway.
- A housekeeper was observed without their mask covering their nose. The IPAC specialist stated that all staff are expected to have their mask cover their nose and mouth and the nose piece should be tightened so it does not fall off.
- Another DA was observed without their eye protection on while residents were nearby. The IPAC specialist stated that staff were expected to wear eye protection at all times when in resident areas.
- A PSW was seen donning a gown in the hallway, far from the resident’s room and did not put on gloves prior to entering a resident’s room with precautions. The PSW discarded their PPE in a waste disposal in the hallway and did not change their mask or clean their eye protection. The PSW was seen with multiple disposable gloves in their pockets that was kept with their keys and name tag. At another time, the same PSW dropped their gown onto the floor while donning it and continued to use that same gown to enter the resident’s room. When the PSW exited the resident’s room, they disposed their mask outside of the room and continued to walk in the hallway for a distance to obtain a new mask in a PPE caddie located far away from the resident’s room. The IPAC

specialist stated that the PPE should be discarded inside the resident's room, face shields should be cleaned and the mask should be changed after exiting the resident's room, PPE should be donned in front of the resident's room and use a cart or trolley to allow the PSW to have donned and doffed their PPE properly.
- A Maintenance Worker (MW) was seen going into a resident's room with precautions without donning any PPE until the Social Worker (SW) reminded them of the need to do so. The MW was noted to not have been wearing any eye protection while they entered the resident's room. The MW was also seen using their work gloves when they went into the resident's room but did not sanitize their work gloves after coming out of the resident's room. The IPAC specialist stated that the MW should sanitize their work gloves after coming out of a resident room with precautions and should have been wearing eye protection when in a resident home area.
- The SW was seen doffing their PPE after coming out of a resident's room with precautions but did not clean their eye protection.
- A visitor was seen going into a resident's room with precautions without donning any PPE. The IPAC specialist stated that the visitor should have worn the appropriate PPE prior to entering the resident's room.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff, contractors and visitors of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with the IPAC Specialist and other staff; Observations made throughout the home during the inspection. [s. 229. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in a resident's plan of care was provided related to the food they were served.

An observation demonstrated that a resident received a type of food. The resident stated that they were allergic to this food and did not consume it. A review of the resident's plan of care confirmed their allergy. The Food Service and Nutrition Manager stated that the resident should not have been served food they were allergic to and the staff should have followed up by checking what they serve. By failing to ensure that this resident received their food in accordance to their diet, there was a potential risk of the resident having an allergic reaction.

Sources: An observation on the resident unit; Review of a resident's plan of care; Interviews with the resident, the Food Service and Nutrition Manager and other staff. [s. 6. (7)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the air temperature was measured and documented in every designated cooling area between a period in May 2021 to June 2021.

A review of the home's air temperature monitoring logs indicated that between a period in May 2021 to June 2021, the air temperature was taken in the designated cooling areas in the home and listed two resident rooms. The inspector noted that there were no additional spaces to add the air temperature in the resident rooms on the log. The Environmental Services Manager (ESM) clarified that on the days that the air temperature was taken on two resident rooms in a unit of the home, the designated cooling area on that unit would not have their air temperature taken. Failure to monitor the air temperatures in designated cooling areas of the home may result in uncomfortable temperatures for residents who would be in that designated cooling area.

Sources: Review of the home's air temperature monitoring logs from May 2021 to June 2021; Interview with the ESM and other staff. [s. 21. (2) 3.]

Issued on this 6th day of July, 2021

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JACK SHI (760), SUSAN SEMEREDY (501)
Inspection No. / No de l’inspection :	2021_882760_0022
Log No. / No de registre :	007419-21, 007421-21, 007713-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 29, 2021
Licensee / Titulaire de permis :	CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.) 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, Cambridge, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 Valley Farm Road, Pickering, ON, L1V-3R6
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Jason Gay

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), you are hereby required to comply with the following order(s) by the date(s) set out below:

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 # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2021_643111_0008, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Conduct monitoring in all home areas to ensure staff, visitors and contractors are adherent to the appropriate Infection Prevention and Control (IPAC) practices.

2. Provide on the spot education and training to staff, contractors and/or visitors not adhering with appropriate IPAC measures.

Grounds / Motifs :

1. Compliance Order (CO) #001 related to O. Reg. 79/10, s. 229 (4) from Inspection #2021_643111_0008 issued on April 30, 2021, with a compliance due date of May 31, 2021, is being re-issued as follows:

The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

A follow-up inspection was conducted, and the staff along with visitors and contractors continued to be noncompliant with the implementation of the home's IPAC program.

Observations were carried throughout the home during this inspection:
- A PSW was observed to be talking to a resident and was not wearing any eye protection. The IPAC specialist stated the PSW should have worn eye

protection.
- A visitor was observed without wearing a mask while they were with a resident. The IPAC specialist stated that the visitor was supposed to wear a surgical mask when they were with the resident.
- A PSW was observed applying two pairs of gloves prior to entering a resident room. The IPAC specialist stated that it is not part of the home's practice to put two pairs of gloves on.
- A contractor was observed going in and out of a resident room on precautions without wearing the appropriate personal protective equipment (PPE). The contractor was later seen wearing the same gown while entering several different resident rooms.
- A dietary aide (DA) was observed with their soiled gloves on while they entered a hallway area. The IPAC specialist stated that the DA should have doffed their gloves after finishing their task and should not have kept it on while they entered the hallway.
- A housekeeper was observed without their mask covering their nose. The IPAC specialist stated that all staff are expected to have their mask cover their nose and mouth and the nose piece should be tightened so it does not fall off.
- Another DA was observed without their eye protection on while residents were nearby. The IPAC specialist stated that staff were expected to wear eye protection at all times when in resident areas.
- A PSW was seen donning a gown in the hallway, far from the resident's room and did not put on gloves prior to entering a resident's room with precautions. The PSW discarded their PPE in a waste disposal in the hallway and did not change their mask or clean their eye protection. The PSW was seen with multiple disposable gloves in their pockets that was kept with their keys and name tag. At another time, the same PSW dropped their gown onto the floor while donning it and continued to use that same gown to enter the resident's room. When the PSW exited the resident's room, they disposed their mask outside of the room and continued to walk in the hallway for a distance to obtain a new mask in a PPE caddie located far away from the resident's room. The IPAC specialist stated that the PPE should be discarded inside the resident's room, face shields should be cleaned and the mask should be changed after exiting the resident's room, PPE should be donned in front of the resident's room and use a cart or trolley to allow the PSW to have donned and doffed their PPE properly.
- A Maintenance Worker (MW) was seen going into a resident's room with

precautions without donning any PPE until the Social Worker (SW) reminded them of the need to do so. The MW was noted to not have been wearing any eye protection while they entered the resident's room. The MW was also seen using their work gloves when they went into the resident's room but did not sanitize their work gloves after coming out of the resident's room. The IPAC specialist stated that the MW should sanitize their work gloves after coming out of a resident room with precautions and should have been wearing eye protection when in a resident home area.
- The SW was seen doffing their PPE after coming out of a resident's room with precautions but did not clean their eye protection.
- A visitor was seen going into a resident's room with precautions without donning any PPE. The IPAC specialist stated that the visitor should have worn the appropriate PPE prior to entering the resident's room.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff, contractors and visitors of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with the IPAC Specialist and other staff; Observations made throughout the home during the inspection.

Severity: There was actual risk of harm to the residents because staff, visitors and contractors of the home continued to be non-compliant with the proper IPAC measures, which may possibly lead to the spread of infectious diseases.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations throughout the home, and the non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: The licensee continues to be in non-compliance with s. 229 (4) of the O. Reg. 79/10, resulting in a compliance order (CO) being re-issued. CO #001 was issued on April 30, 2021, (Inspection 2021_643111_0008) with a compliance due date of May 31, 2021. In addition, the home has had non-compliance to the same subsection in the past 36 months as follows:

-issued a Voluntary Plan of Correction (VPC) on October 28, 2020 during inspection #2020_603194_0016.
-issued a Voluntary Plan of Correction (VPC) on July 27, 2020 during inspection #2020_598570_0006. (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 26, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29th day of June, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jack Shi

Service Area Office /
Bureau régional de services : Central East Service Area Office

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 29, 2021	2021_882760_0023	008521-21	Complaint

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road Pickering ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JACK SHI (760), SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 22, 23, 24, 25, 2021.

The following intakes were completed in this complaints inspection:

A log related to sufficient staffing.

During the course of the inspection, the inspector(s) spoke with visitors, residents, Family Council President, Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

During the course of the inspection, the inspectors toured the home, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:
Sufficient Staffing

During the course of this inspection, Non-Compliances were not issued.
- **0 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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.

Issued on this 29th day of June, 2021

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 30, 2021	2021_882760_0031	010682-21, 012244-21, 012761-21	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road Pickering ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JACK SHI (760), JOVAIRIA AWAN (648)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 24, 25, 26, 27, 2021.

The following intakes were completed in this critical incident inspection:

A log was related to a fall;
A log was related to an allegation of resident abuse;
A follow up log to Compliance Order (CO) #001, O. Reg 79/10 s. 229 (4), related to infection prevention and control, issued under inspection # 2021_882760_0022, on June 29, 2021, with a compliance date of July 26, 2021.

During the course of the inspection, the inspector(s) spoke with Vice President for Infection Control, Infection Prevention and Control Specialist, Senior Director of Clinical Support, a Registered Nurse (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW).

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, reviewed home's air temperature monitoring logs, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (4)	CO #001	2021_882760_0022	760

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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's plan of care provided clear directions to the staff related to the use of a fall prevention intervention.

A review of the progress notes indicated that the resident sustained a fall and was provided a fall prevention intervention. An RPN confirmed that they had applied this intervention. The resident sustained a second fall and was diagnosed with an injury. A PSW stated they did not notice that this resident's fall prevention intervention was present at the time of their second fall. The Senior Director of Clinical Support confirmed that the directions in this resident’s plan of care was not clear related to the use of this fall prevention intervention at the time of their second fall. The use of this intervention may have benefited the resident at preventing falls, if it was followed through, from the resident’s plan of care.

Sources: A resident’s progress notes, plan of care; Interviews with an RPN, a PSW and other staff. [s. 6. (1) (c)]

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 30th day of August, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 10, 2022	2022_861194_0003	002504-22	Proactive Compliance Inspection

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road Pickering ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CHANTAL LAFRENIERE (194), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): February 23, 24, 25, 28, March 1, 2, 3, 4, 7, 2022

During the course of the inspection, the inspector(s) spoke with Residents, Substitute Decision Maker (SDM) of identified residents, Presidents of Resident and Family Councils, Executive Director (ED), Director of Care (DOC), Director of Clinical Care (DCC),Clinical Manager, Vice President of Infection Prevention and Control, Infection Prevention and Control (IPAC) lead, Regional Clinical Coordinator, Program Manager, Social Worker, Senior Public Health Inspector, Nutrition Manager, Dietary Aide, Director of Clinical Support, Senior Executive Director, Registered Nurse (RN), Registered Practical Nurse (RPN) Personal Support Worker (PSW), Housekeeping Staff, COVID-19 Tester and Screener.

During the course of the inspection the inspectors observed staff to resident provision of care, toured the home, observed IPAC practices, dining service and medication administration. The inspectors reviewed the relevant IPAC, medication, dietary, Skin and Wound, Falls, Pain and Resident abuse Policy/Programs. The inspectors reviewed clinical health records of identified residents, Resident Council Minutes, Family Council Minutes, Quality Improvement evaluation and Resident/Family satisfaction survey and action plan.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care for a resident was provided as specified.

The plan of care for a resident confirmed that fall interventions and an assistive aide were to be in place.

The resident was observed with no fall interventions and no assistive aide in place. A PSW confirmed that the falls intervention should have been in place, stating that the resident did not have an assistive aide. The resident was observed a second time, with no falls interventions or assistive aide. Another PSW confirmed that the falls intervention should have been in place, but stated there were no assistive aide for the resident. Physio Therapist (PT) #141 confirmed that the resident's assistive aide was still active. The resident was observed a third time, with no assistive aide. Failing to provide the care set out in the plan of care as specified, increases the risk of harm to the resident.

Source: observation of the resident, review of residents clinical health records, Interview with resident and staff. [s. 6. (7)]

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 by ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that food and fluids are served at a temperature that is both safe and palatable to the residents.

During dining observations residents were observed to have uneaten food on their plates. Interviews were conducted with residents for food satisfaction. Residents indicated that the soup and the main meal were cold when served.

Review of the pre-meal service temperature log indicated the food was within the acceptable range and the homes policies for food temperatures.

Interview with a Dietary Aid and Nutrition Manager (NM) indicated that food temperatures were to be taken prior to the start of the meal service. While the Inspector was observing, the NM took the food temperatures from the steam table. The main meal was below the acceptable range as per the homes policy. NM indicated that the serving dish for the main meal was not placed directly in the steam table.

Review of the Food Committee meeting minutes for 2021 identified several complaints from residents about the temperature of food being served.

When the serving dish was not correctly placed into the steam table to maintain the temperature, residents were at risk of receiving food that was served at a temperature that was unsafe and not palatable.

Sources: observations, resident interviews, interview with DA and NM, End Point Food Temperature & Appendix 1 – End Point Cooking Temperature Chart. [s. 73. (1) 6.]

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 by ensuring that food and fluids are being served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The Licensee failed to ensure that all staff participate in the implementation of the Infection Prevention and Control Program (IPAC).

The homes “PPE guide” directed that staff were to apply PPE correctly before entering a room with additional precautions and staff were to remove the PPE in a sequence that prevents self-contamination. Putting it on and removing of PPE posters were noted on several resident rooms. The guide directed the use of signage for Aerosol generating medical procedure (AGMP) use at the home. Review of the contact precautions and droplet precaution policies directed that signage was to be placed outside the resident room for additional precaution. Interview with IPAC lead and Regional Clinical Coordinator confirmed the home's application of the PPE guide.

An RPN confirmed that two residents were using an AGMP at the home, there was no precaution signage or PPE's available at one resident’s room, and no N95 masks available at the other resident's PPE caddy.

An RPN confirmed that a resident was under droplet and contact precautions with use of N95 mask. There were no N95 masks available in the PPE caddy . Another resident's room was observed to have signage for droplet and contact precautions with N95 to be

worn, there were no N95 available for staff in the PPE caddy.

Multiple residents' in semi-private rooms were observed to have a contact precaution sign with PPE caddy in place. The signage did not indicate for which resident the additional precautions were for. A PSW confirmed that they would use the PPE for both residents as it was not identified who the precautions were used for. PSW stated that at times the additional precautions were discussed at report, or a co-worker might say “stop” then you would know not to go in without equipment. The PSW stated that they could ask the nurse but would be told to review the plan of care.

IPAC #102 confirmed that two residents were under contact precautions, there were no contact precaution signs or PPEs readily available. An RPN confirmed that a resident was under droplet and contact precautions with N95 precautions, there were no N95 masks available in the PPE caddy. A Housekeeper (HSKP) was observed improperly putting on PPE prior to entering the room. The HSKP was observed exiting the room to obtain equipment off the housekeeping cart in the hallway, without removing and reapplying PPEs. Upon exiting the room the HSKP removed the gown, then walked away with gloves, face shield and N95 mask in place. A PSW was observed sitting outside the resident’s room wearing full PPE and N95 mask. The PSW entered the resident room to redirect the resident. The PSW then returned to sit in the chair outside the resident’s room, without having cleaned or discarded their face shield and or changing their mask.

Two Housekeepers (HSKP) were observed cleaning isolation rooms. One room was under droplet and contact precautions with N95 signage at the door and the other room was under droplet and contact precautions without N95 signage on the door. The first HSKP was observed exiting the isolation room taking off PPE’s and reapplying gloves. The HSKP picked up the garbage bag from the floor in room, holding it against their uniform, exiting the room, to the soiled utility room. The Housekeeper's mask and shield were not removed or changed. When exiting the room the second HSKP, removed their PPE’s but their surgical mask and shield were not changed. There was no N95 mask used. At the doorway to room the second HSKP cleaned their hands and put on their gown. They entered the room without changing their mask or shield. The same was observed with the garbage bag touching their uniform after removing their gown. The first HSKP informed inspector #623 that they did not need to remove their mask and shield when leaving an isolation room, stating that they changed it before entering the next room. The HSKP stated that they did not require to wear a gown when carrying garbage out of an isolation room, where the garbage was touching their uniform. The HSKP

stated that they were wearing the same mask and shield for both isolation rooms, stating they did not know they needed to change them. The HSKP confirmed that they did not wear and N95 while cleaning the isolation room, stating that they did not need to wear them anymore. The HSKP stated that they used the same cleaning cloth from room to room and that this was ok, as the solution was a disinfectant. Failing to ensure that staff participate in the implementation of the IPAC program, increases the risk of transmission of infection.

Source: Observation of residents with additional precautions in place, Review of the homes PPE Guide, interview with staff. [s. 229. (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 by ensuring that all staff participate in the implementation of the Infection Prevention and Control program, to be implemented voluntarily.

Issued on this 24th day of March, 2022

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 4, 2022	2022_927957_0013	013209-21, 020305-21, 002288-22	Complaint

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road Pickering ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CATHERINE OCHNIK (704957)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 29, 30, and 31, 2022

The following intakes were completed in this Complaint Inspection:

Complaint Log# 013209-21 related to wound care concerns.
Complaint Log# 020305-21 related to concerns with plan of care.
Complaint Log# 002288-22 related to concerns with documentation of care.

An Infection Prevention and Control (IPAC) inspection was also completed as part of this inspection.

During the course of the inspection the inspector toured the home, observed residents and the care provided to them, observed resident rooms and common areas, reviewed health care records, plans of care for identified residents, home policies and procedures, and other pertinent documents.

During the course of the inspection, the inspector(s) spoke with the Associate Director of Operations and Clinical Support, IPAC Lead, Personal Support Workers (PSWs), Registered Nurses (RNs), Wound Care Lead, IPAC Auditors, an entrance screener, a housekeeping staff member and residents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were not issued.
- **0 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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.

Issued on this 5th day of April, 2022

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 16, 2022	2022_927957_0010	002862-22	Critical Incident System

Licensee/Titulaire de permis

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766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Orchard Villa
1955 Valley Farm Road Pickering ON L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CATHERINE OCHNIK (704957)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 10 and 11, 2022.

The following intake was completed in this Critical Incident Inspection, related to alleged staff to resident abuse.

During the course of the inspection the inspector toured the home, observed residents, resident rooms and common areas, reviewed health care records, plans of care for identified residents, home policies and procedures, investigation notes, and other pertinent documents.

During the course of the inspection, the inspector(s) spoke with The Director of Care (DOC), a Physician, Durham Regional Police Services Detectives, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 staff to resident abuse of resident #001, which resulted in harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director.

On a specified date, Registered Practical Nurse (RPN) #104 rushed to resident #001's room after Personal Support Worker (PSW) #105 called out for help. While both staff members were present in the room, resident #001 made an allegation of staff to resident abuse against PSW #105. Resident #001 was sent to hospital, and it was discovered that they had sustained an injury.

The CIS Report indicated that the allegation of staff to resident abuse toward resident #001 was reported to the Ministry of Long-Term Care on a specified date. Clinical record review showed that the incident had occurred at an earlier date.

Orchard Villa's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" (RC-02-01-02) Last Updated June 2021 states on page 4 that "any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior supervisor on shift at that time. Note: In Ontario, in addition to the above, anyone who

suspects or witnesses abuse, incompetent care or treatment of a resident, misappropriation of funds (resident or funds provided to the licensee under the LTCHA or the Local Health Systems Integration Act), and/or neglect that causes or may cause harm to a resident is required to contact the Ministry of Health and Long Term Care (Director) through the Action Line and is protected by legislation (Whistleblower's protection) from retaliation."

In an interview, RPN #104 acknowledged that they did not report the allegation of abuse made by resident #001 to the Ministry of Long-Term Care.

During an interview, the Director of Care (DOC #100) verified that the allegation of abuse made by resident #001 was not reported to the Ministry of Long Term Care immediately.

Sources: CIS Report #2693-000006-22, Orchard Villa's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" (RC-02-01-02) Last Updated June 2021, the home's investigation notes, resident #001's progress notes, interviews with RPN #104 and DOC #100. [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 allegations of staff to resident abuse are reported to the director immediately., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of an alleged incident of abuse of resident #001 that the licensee suspected may have constituted as a criminal offence.

CIS Report indicated that an allegation of staff to resident abuse toward resident #001, which resulted in resident #001 sustaining an injury, was reported to the Durham Regional Police Service (DRPS) on a specified date.

In an interview, RPN #104 acknowledged that they did not immediately report the allegation of abuse made by resident #001 to police.

During an interview, the DOC #100 verified that the allegation of abuse made by resident #001 was not reported to DRPS immediately.

Sources: CIS Report #2693-000006-22, the home’s investigation notes, resident #001’s progress notes, interviews with Detective #110, RPN #104 and DOC #100. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance To ensure that the appropriate police force is immediately notified of any alleged or suspected incident of abuse of a resident that the licensee suspects may constitute a criminal offense., to be implemented voluntarily.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 16th day of March, 2022

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

Original Public Report

Report Issue Date June 8, 2022
Inspection Number [2022_1193_0001]
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
Long-Term Care Home and City
Orchard Villa, Pickering

Lead Inspector **Inspector Digital Signature**
Sami Jarour (570)

Additional Inspector(s)
Catherine Ochnik (704957)

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 4, 5, 9, 10, 11, 12 and 13, 2022.

The following intake(s) were inspected:

- Log #016398-21 related to a fall incident.
- Log #017489-21 related to an allegation of abuse.
- Log #018164-21 related to a fall incident.
- Log #001546-22 related to failure/breakdown of ventilation system (heating).
- Log #001673-22 related to an allegation of abuse.
- Log #006715-22 related to a fall incident.
- Log #008302-22 related to a fall incident.

The following **Inspection Protocols** were used during this inspection:

- Infection Prevention and Control (IPAC)
- Falls Prevention and Management
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Safe and Secure Home

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CentralEastSAO.moh@ontario.ca

INSPECTION RESULTS

WRITTEN NOTIFICATION - REPORTING CERTAIN MATTERS TO DIRECTOR

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 [s. 24. (1)]

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone, that resulted in harm or risk of harm had occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care (MLTC) indicated an allegation of abuse by a co resident toward resident #008 was not immediately reported to the Director.

A review of progress notes for resident #008 indicated the resident reported the allegation to registered nurse (RN) #110 four days prior the submission of the CIR.

Interview with RN #110 confirmed that they did not report the incident.

Interview with the DOC acknowledged the late reporting of the incident and indicated the incident should have been immediately reported to the MLTC when it was reported by the resident.

Sources: Critical Incident Report (CIR), resident #008's health records, and interviews with the RN #110 and the DOC. [570]

WRITTEN NOTIFICATION - AIR TEMPERATURE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 *s. 21. (1)*

The licensee has failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care (MLTC) related to failure of the home's heating, ventilation, and air conditioning (HVAC) system. On the date of the incident, the CIR indicated air temperatures on two residents' home areas started to gradually fluctuate below 22 degrees Celsius.

A review of the home's temperature logs for the month of January 2022, indicated air temperatures in the home dropped below 22 degrees Celsius on the date of the incident in three residents' home areas.

Interview the Executive Director (ED) acknowledged air temperatures fluctuated below 22 degrees Celsius on the date of the incident.

Sources: Critical Incident Report (CIR), air temperatures logs, and interview with the Executive Director (ED). [570]

COMPLIANCE ORDER CO#001 PLAN OF CARE

NC#003 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021, s. 6. (2)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order - FLTCA 2021, s. 155. (1) (a)

The Licensee has failed to comply with s. 6. (2) of the FLTCA.

Specifically, the licensee shall:

1. Educate registered staff in one residents' home area regarding the home's process for updating resident care plans with interventions based on resident's post falls assessment.

2. Keep a record of the content of this training, the date the training was provided, the person conducting the training and those that attended.

Grounds

Non-compliance with: FLTCA, 2021 s. 6. (2)

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East Service Area Office
33 King Street West, 4th Floor
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CentralEastSAO.moh@ontario.ca

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and on the needs and preferences of that resident.

Rationale and Summary

A Critical Incident Report (CIR) submitted to the Ministry of Long-Term Care (MLTC) indicated that resident #004 sustained a fall with injury. The resident was transferred to hospital and returned with a specified diagnosis and was placed on palliative care. The resident passed away four days after returning from hospital.

Progress notes review indicated that resident #004 had a previous fall and a post falls assessment completed indicated that having universal falls precautions could have prevented the fall from taking place.

Resident #004's plan of care reviewed post previous fall, indicated that they were at a risk of falls. Interventions in the plan of care included specified interventions for falls.

In an interview, Associate Director of Operations and Clinical Support (ADOCS) acknowledged that falls interventions noted in the post falls assessment should have been specific to the resident and that the care plan should have been updated to reflect those changes from the post falls assessment.

A post falls assessment completed for resident #004's second fall indicated two specified interventions that would be added to the resident's care plan.

Resident #004's care plan, indicated that they were at a risk of falls. Interventions in the care plan included specified falls prevention intervention but did not include the two specified interventions.

In an interview, RN #119 acknowledged that falls interventions for resident #004 were not adequate.

The home's Falls Prevention and Management Program Policy (RC-15-01-01) Appendix 2 - Fall Risk Assessment Tool (AB, SK, ON) Last Updated: August 2019 (RC-15-01-01) A2 indicates that a high Morse fall risk score action is to implement resident-specific Fall Prevention interventions.

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As a result of resident #004's plan of care not being based on the post falls assessment completed on January 24, 2022, there was actual harm to resident #004, as they died as a result of the injury sustained from the fall.

Sources: Critical Incident Report , the home's "Falls Prevention and Management Program Policy" (RC-15-01-01) policy Appendix 2 - Fall Risk Assessment Tool (AB, SK, ON) Last Updated: August 2019 (RC-15-01-01) A2, resident #004's progress notes, clinical record review, interviews with ADOCS and RN #119. [704957]

This order must be complied with by July 6, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.

This is Exhibit “I” referred to in
the Affidavit of NATALIE
MEHRA sworn before me this
18th day of April, 2024

A Commissioner for Taking Affidavits

Canada · MARKETPLACE

These nursing home chains have the highest COVID-19 death rates in Ontario, data analysis finds

Companies say higher prevalence of shared rooms in for-profit homes influenced death rates

Melissa Mancini, Katie Pedersen, David Common · CBC News ·
Posted: Dec 18, 2020 4:00 AM EST | Last Updated: December 18, 2020

Protesters gather outside Hawthorne Place Care Centre in Toronto on May 31, 2020. The home is owned by Rykka Care Centres, a nursing home chain with one of the highest COVID-19 death rates in Ontario. (Frank Gunn/The Canadian Press)

comments

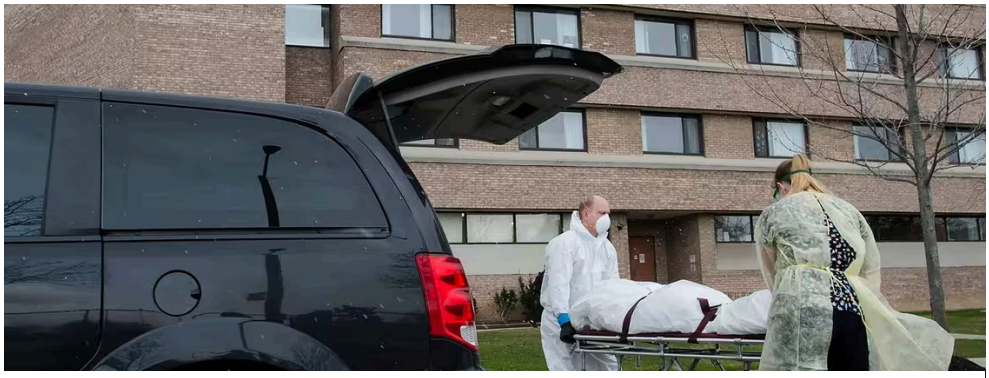
Not all for-profit long-term care homes in Ontario are equal when it comes to containing COVID-19, an analysis of provincial data by CBC's *Marketplace* has found.

While previous analysis showed municipal and non-profit homes consistently fared better during the coronavirus pandemic and pointed to potential reasons why that might be, a breakdown of deaths per 100 beds by company shows Southbridge and Rykka Care Centres homes had higher death rates than their for-profit peers.

The latest analysis takes data from the Ministry of Long-Term Care on outbreaks in Ontario homes until Dec. 13 and pairs it with home ownership data from the province. It looks only at homes that have been exposed to COVID-19, eliminating homes that have had no outbreaks in areas of the province where there is no community transmission.

In homes that have had at least one outbreak between the beginning of the pandemic and Dec. 13, Southbridge Care Homes lost nine residents per 100 beds. There were 8.6 deaths per 100 beds at Rykka Care Centres homes.

Sienna homes had a death rate of 6.5, Revera's homes had a rate of 6.3 and Chartwell 4.6, while Extendicare was at 3.6, closer to the overall industry average of 3.7.



These nursing homes have the highest COVID-19 death rates in Ontario (Marketplace)

▶ 3 years ago 2:32

A CBC Marketplace data analysis found Southbridge and Rykka homes had higher death rates than other for-profit homes in Ontario.

All of those companies had death rates higher than the non-profit and municipal categories. Non-profits had an average of 2.8 deaths per 100 beds while municipal homes averaged 1.4. The average death rate in for-profit homes is 5.2.

Pat Armstrong, a professor at York University in Toronto who studies best practices in long-term care, said her research shows consistent differences among ownership types when it comes to other quality-of-care indicators.

"Certainly ownership is a factor and we've known that for a long time," she said. "It doesn't mean that all of the for-profits are terrible or that all of the government-owned ones are wonderful, but the pattern has been pretty consistent for quite a while now."

Long before COVID-19 arrived, there were more transfers to hospitals, more deaths and more bed ulcers in for-profit homes, Armstrong said.

Pat Armstrong a professor of sociology at York University and an expert in long-term care, said as for the factors that lead to the high death rates: 'I don't think that there have been very many changes whatsoever.' (Submitted by Pat Armstrong)

All homes also need more staff, she said, but it's "particularly the case in the for-profits."

On Tuesday, the province's COVID-19 Science Advisory Table identified chain ownership as one of the most important risk factors "for the magnitude of an outbreak, and the number of resulting resident deaths."

Applying for more beds

But companies that have fared poorly in the pandemic continue to apply for more beds.

Recently, as part of a redevelopment plan, the province awarded 87 additional beds to Orchard Villa, a Pickering, Ont., home owned by Southbridge where 70 residents died in the first wave.

More than 26,000 people have signed a petition asking the government not to let Rykka, which owns two of the five homes the Canadian Armed Forces were deployed into during the first wave, buy a not-for-profit care home in Toronto.

"My grandfather is a resident at Rose of Sharon, the only Korean-cultural long-term care home in Toronto," wrote Sandra Kang in the petition. "Rykka Care Centres LP, a for-profit company, wants to take its licence over and run the home — even though they have consistently failed to protect the lives and rights of their residents and workers."

The closing date for consultation on the proposal ended on Dec. 14.

Ontario nursing home chains with death rates above provincial average

Owned and Operated	Deaths per 100 beds
Southbridge	9.00
Rykka Care Centres	8.60
Sienna	6.54
Revera	6.26
Chartwell	4.63
Independent for-profit	4.56
All homes	**3.75**
Non-Profit	**2.80**
Municipal	**1.35**

Several long-term care chains in Ontario that operate 500 beds or more have COVID-19 death rates above the provincial average as of Dec. 13. (CBC)

Companies dispute CBC analysis

Overall, about 79 per cent of long-term beds in Ontario are in homes that have had at least one COVID-19 case inside, according to CBC's analysis.

Marketplace's review only included beds in homes that had at least one outbreak. In Ontario, an outbreak is defined as a single case, involving either a staff member or resident. Homes that have had no COVID-19 cases, often in areas of the province with little or no community transmission, were not included.

Nicola Major, director of communications and initiatives for Responsive Group, the operating partner of Rykka Care Centres, said the analysis is "flawed, and not an accurate reflection of the state of long-term care in Ontario."

"Most long-term care homes that experienced a COVID-19 outbreak early in the pandemic were significantly impacted, no matter the ownership structure," she said.

Orchard Villa in PIckering, Ont., saw one of the highest death counts in the province early in the pandemic. The home is owned by Southbridge. (Frank Gunn/The Canadian Press)

Rykka and some other chains said locations that did not have any COVID-19 cases inside should have been included in the analysis. Rykka has two small long-term care homes in Stoney Creek that have had no outbreaks.

But even if CBC's statistics had included those homes, the death rate for the company would be 8.1 instead of 8.6, still vastly higher than the average in for-profit homes.

Southbridge Care Homes didn't respond to repeated requests for comment over the span of almost two weeks.

Home design a factor, but not the only one: experts

Many of the chains that had a higher-than-average death rate pointed to age of homes as a factor. As CBC reported in June, many of the worst outbreaks took place in older buildings where there is less space for distancing and where many residents share rooms.

Since that report, medical journals have published studies that show similar findings.

CBC's analysis shows that while shared rooms are a risk factor, some companies appear to mitigate those risks better than others.

Homes that meet only 1972 facility standards that allow for narrow hallways and four-person shared rooms are labelled "C" on a provincial scale that includes designations of "New," " A," "B," "C" and "D." Those homes represent almost one-third of Ontario long-term care beds. The majority of "C" beds exist in for-profit homes.

Many Ontario long-term care homes are older buildings with four-person shared rooms, most of which are owned by for-profit companies, according to data from the Ministry of Long-Term Care. (Evan Mitsui/CBC)

Ontario changed its standards for homes in 1998, mandating things such as a limit to two residents per room. Homes that didn't meet the new standards were allowed to keep operating, with the expectation they would upgrade eventually.

But experts say existing problems in long-term care contributed to the difference in COVID-19 death rates between for-profit and not-for-profit homes.

Studies done pre-pandemic have found there are lower staffing levels in for-profit care, which would have affected care levels during an outbreak, said Armstrong.

Having fewer workers taking care of residents with dementia would be a problem during a pandemic, she said.

"That makes it harder to talk them into doing things from eating to wearing a mask to not wandering out of their room."

Timing of outbreaks

Companies with homes hit hard by the pandemic also cited timing of the outbreaks as a factor for why high numbers of deaths occurred.

Sienna Senior Living, which has seen 6.5 deaths for every 100 beds in homes affected by COVID-19, cited community spread and "the delay in provincial infection prevention and control protocols and changes to public health protocols during Wave 1" as two reasons for large outbreaks.

The company is dealing with an active outbreak that has killed 21 residents at Rockcliffe Community Care in Scarborough.

An active outbreak of COVID-19 has killed 21 residents at Rockcliffe Community Care in Scarborough, Ont. (Michael Charles Cole/CBC)

Revera had a similar death rate, with 6.3 deaths per 100 beds. The company called the focus on ownership "simplistic" and said "community spread is the main predictor for outbreaks and ward rooms with shared bathrooms are the main predictor for outcomes of outbreaks."

Extendicare, which had a death rate in line with overall death rate in for-profit homes, said "third-party expert evidence shows that a long-term care home's age, size and proximity to community spread are the causative predictors of a severe outbreak, not who owns the home."

Variations among older homes

Still, some older homes with ward rooms and shared bathrooms are doing better than others when it comes to containing the coronavirus.

Toronto has had significant community transmission throughout the pandemic. Sherbourne Place (non-profit) and Elm Grove Living Centre (for-profit) each have 126 "C" class beds and have seen 18 and 19 deaths respectively — a death rate of about 15 per 100 beds.

A resident of Eatonville with COVID-19 is wheeled from the home in Etobicoke, Ont., in April 2020. Eatonville is owned by Rykka Care Homes. (Nathan Denette/The Canadian Press)

Meanwhile, municipally run Castleview Wychwood has one of the biggest homes in Toronto, with 456 beds, which are also "C" class, but government data indicates it has had fewer than five COVID-19 deaths, or less than one death per 100 beds.

The five homes with the most deaths in Toronto all have "New," "A" or "B" designations, which don't allow for four-bed wards. Only one is a for-profit facility.

Chartwell pointed to similar risk factors for outbreaks, as well as timing of outbreaks, saying the company's two hardest-hit homes were older-design homes that "went into outbreak early in the pandemic before the asymptomatic nature of the transmission of the virus was understood."

Why haven't for-profit homes updated their buildings?

Some municipal homes that have redeveloped have done so with the help of city and town councils chipping in from the local tax base, said Lisa Levin, the CEO of Advantage, a group representing the interests of non-profit nursing homes in Ontario.

"Not-for-profits have to fundraise if they're going to redevelop their homes. They have to fundraise extensively. And the ones that have been able to redevelop have been successful at doing that."

But it is a complicated issue, said Tamara Daly, director of York University's Centre for Aging Research and Education.

- MARKETPLACE **Ont. nursing homes have had 22 years to do safety upgrades. COVID-19 reveals deadly cost of delay**

- MARKETPLACE **85% of Ont. nursing homes break the law repeatedly with almost no consequences, data analysis shows**

In a small home, the subsidies to rebuild can top $20 million in public funding over 25 years for capital investments on top of what the government pays a home for care, said Daly.

"We the public pay for, with public funds, these buildings, and they are owned privately," she said.

Methodology note:

CBC used publicly available data on COVID-19 outbreaks and matched it with data on home ownership. CBC isolated all homes that have had at least one outbreak between the start of the pandemic and Dec. 13 to compare how different companies managed to contain the virus once exposed. Homes that had no cases, which were often in areas of the province with no community transmission, were not included in the rates.

For each parent company, its total deaths per total potential exposures (i.e. beds in homes with outbreaks) were used to calculate death rates. Parent companies were not counted as a "chain" if they operated fewer than 500 beds.

Some long-term care chains manage independent for-profit or non-profit homes but are not the owner/operator. Only homes owned and operated by the parent company were included in the analysis.

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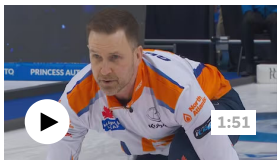
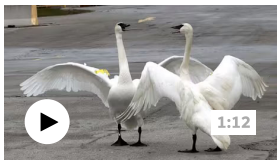


Canada's Brad Gushue wins Players' Championship on miraculous final shot



VIDEO

#TheMoment these lovebird swans were reunited

The National

VIDEO

Check out this massive wooden trestle in the tiny Alberta hamlet of Rochfort Bridge

Our Edmonton

Pickup trucks flip after collision in East St. Paul

Spire exch

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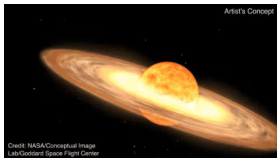
UPDATED

Multiple arrests, 19 charges laid in $22.5M Pearson gold heist

Lucas Powers

Canada - Toronto |



A 'new' star will light up the sky soon and you can see it for yourself

Nicole Mortillaro

Science |

Uniform or costume? Athletes sound off on revealing U.S. women's Olympic track kit

Natalie Stechyson

Canada

U.A.E. hit with heaviest rain ever recorded in the country

Jon Gambrell

World

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OHC, et al. Applicants	and	MINISTER OF LONG TERM CARE Respondent	Court File No: DC-24-00000007-00JR

ONTARIO
SUPERIOR COURT OF JUSTICE

Proceeding commenced at TORONTO

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