The Corporation of the City of Kawartha Lakes

AGENDA

VICTORIA MANOR COMMITTEE OF MANAGEMENT

VMC2017-04
Monday, April 24, 2017
9:30 A.M.
Victoria Manor Boardroom
Victoria Manor, Second Floor
220 Angeline Street South, Lindsay, Ontario

MEMBERS:

Councillor Doug Elmslie
Councillor Gerard Jilesen
Councillor Mary Ann Martin
Councillor John Pollard
Councillor Kathleen Seymour-Fagan

Accessible formats and communication supports are available upon request.

		Pages
1.	CALL TO ORDER	
2.	ADOPTION OF AGENDA	
3.	DISCLOSURES OF PECUNIARY INTEREST	
4.	DEPUTATIONS AND PRESENTATIONS	
5.	APPROVAL OF THE MINUTES OF THE PREVIOUS MEETING	3 - 6
6.	BUSINESS ARISING FROM PREVIOUS MEETINGS	
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9.	CLOSED SESSION	
9.1	Closed Minutes, Victoria Manor Committee of Management, March 20, 2017, Municipal Act, 2001 s.239(2)(b)(d)(g)	
9.2	Victoria Manor Confidential Operations Report to Committee of Management, April 24, 2017, Municipal Act, 2001 s.239(2)(b)(d)(e)	
10.	MATTERS FROM CLOSED SESSION	
11.	OTHER NEW BUSINESS	
12.	NEXT MEETING	
	May 15, 2017, Victoria Manor Boardroom, commencing at 9:30 a.m.	
13.	ADJOURNMENT	

The Corporation of the City of Kawartha Lakes

MINUTES

VICTORIA MANOR COMMITTEE OF MANAGEMENT

VMC2017-03
Monday, March 20, 2017
9:30 A.M.
Victoria Manor Boardroom
Victoria Manor, Second Floor
220 Angeline Street South, Lindsay, Ontario

MEMBERS:

Councillor Doug Elmslie
Councillor Gerard Jilesen
Councillor Mary Ann Martin
Councillor John Pollard
Councillor Kathleen Seymour-Fagan

Accessible formats and communication supports are available upon request.

1. CALL TO ORDER

Chair Elmslie called the meeting to order at 9:34 a.m. Councillors G. Jilesen, M.A. Martin, J. Pollard and K. Seymour-Fagan were in attendance.

Administrator Pamela Kulas, Director of Human Services Rod Sutherland, Executive Assistant Holly Russett and Sienna Senior Living VP Operations and Long Term Care Sanja Freeborn were also in attendance.

2. ADOPTION OF AGENDA

VMCM2017-025
Moved By Councillor Martin
Seconded By Councillor Jilesen

RESOLVED THAT the agenda be adopted as circulated.

CARRIED

3. DISCLOSURES OF PECUNIARY INTEREST

There were no declarations of pecuniary interest noted.

4. DEPUTATIONS AND PRESENTATIONS

4.1 Family Council update - Pat Herlihey, Family Council President presenting

VMCM2017-026
Moved By Councillor Martin
Seconded By Councillor Jilesen

RESOLVED THAT the presentation by Pat Herlihey regarding Family Council update, be received.

CARRIED

4.2 Our Willed Future - Pam Kulas presenting

VMCM2017-27
Moved By Councillor Pollard
Seconded By Councillor Martin

RESOLVED THAT the presentation by Pamela Kulas, regarding 'Our Willed Future', be received.

CARRIED

5. APPROVAL OF THE MINUTES OF THE PREVIOUS MEETING

VMCM2017-028
Moved By Councillor Seymour-Fagan
Seconded By Councillor Pollard

RESOLVED THAT the minutes of the Victoria Manor Committee of Management meeting held on February 27, 2017 be adopted as circulated.

CARRIED

6. BUSINESS ARISING FROM PREVIOUS MEETINGS

None

7. CORRESPONDENCE

None

8. REPORTS

8.1 Victoria Manor Operations Report to Committee of Management, February 2017

VMCM207-029
Moved By Councillor Seymour-Fagan
Seconded By Councillor Martin

RESOLVED THAT the Victoria Manor Operations Report to Committee of Management, February 2017, provided by Sienna Senior Living, be received for information.

CARRIED

8.2 VMC2017-06 Victoria Manor 2017-18 Quality Improvement Plan

VMCM2017-030
Moved By Councillor Pollard
Seconded By Councillor Jilesen

RESOLVED THAT Report VMC2017-16, "Victoria Manor 2017/18 Quality Improvement Plan for Ontario Long Term Care Homes", be received for information; and

THAT the Chair of the Victoria Manor Committee of Management be authorized to sign said Quality Improvement Plan as attached.

CARRIED

9. CLOSED SESSION

VMCM2017-031
Moved By Councillor Pollard
Seconded By Councillor Martin

RESOLVED THAT the Victoria Manor Committee of Management convene into closed session in order to consider matters on the Monday, March 20, 2017 Closed Session Agenda and that are permitted to be discussed in a session closed to the public pursuant to Section 239(2) of the Municipal Act, S.O. 2001. S.25

CARRIED

10. MATTERS FROM CLOSED SESSION

None

11. OTHER NEW BUSINESS

None

12. NEXT MEETING

April 24, 2017, Victoria Manor Boardroom, commencing at 9:30 a.m.

13. ADJOURNMENT

VMCM2017-036
Moved By Councillor Seymour-Fagan
Seconded By Councillor Jilesen

RESOLVED THAT the Victoria Manor Committee of Management Meeting adjourn at 10:28 a.m.

CARRIED

THE CORPORATION OF THE CITY OF KAWARTHA LAKES

Health & Social Services Department
M E M O R A N D U M

TO:	**Victoria Manor Committee of Management**
FROM:	**Pamela Kulas, Administrator**
DATE:	**April 24, 2017**
RE:	***Inspection Report – Ministry of Labour***

A Ministry of Labour Inspection was conducted on February 1, 2017. During the inspection the inspector met with members of the Joint Occupational Health and Safety Committee and the Director of Care.

During the course of the inspection the home received 1 order.

To summarize:

1. **Employer policy with regards to workplace violence was last reviewed in 2013**
    a. Corrective Actions:
        i. 2017 Violence in the Workplace policy from the management company (Sienna) has been implemented
        ii. Copy of the 2017 Violence in the Workplace policy was provided to all employees in February 2017

Ministry of Labour Report.pdf

Ministry of Labour

Safe At Work Ontario

Ontario

Operations Division | Occupational Health and Safety

Field Visit Report

OHS Case ID: **02776LCQN159**
Field Visit no: **02776LCQN160** Visit Date: **2017-FEB-01** Field Visit Type: **INITIAL**
Workplace Identification: **VICTORIA MANOR** Notice ID:
220 ANGELINE STREET SOUTH, LINDSAY, ON, CANADA K9V 4R2

Telephone:	JHSC Status:	Work Force #:	Completed %:
(705) 324-3558	**Active**	**170**	

Persons Contacted: **JENNIFER VANDERBURG- D.O.C, JAMEY COONS- HR GENERALIST, GLORIA ALTON- JHSC WORKER CO-CHAIR**
Visit Purpose: **COMPLAINT/REPRISAL INVESTIGATION.**
Visit Location: **WORKPLACE ADMINISTRATIVE OFFICES.**
Visit Summary: **ORDERS ISSUED, SEE DETAILED NARRATIVE.**

Detailed Narrative:

This inspection was conducted after the Ministry received a number of complaints from workers at this workplace. Each of the workers indicated that they had been the victim of assault by residents including being struck in the face, grabbed and pushed.

Workers, including the worker representative from the joint health and safety committee put forward a number of concerns relating to workplace violence including:

- The employer has taken insufficient steps to protect workers from workplace violence
- That workers are unaware of the employers program regarding workplace violence
- That incidents of assault are increasing and becoming more severe
- The workers who report workplace violence are subjected to reprisal

The provisions of the Occupational Health and Safety Act specific to workplace violence prevention are structured such that a significant burden is placed on the employer and the internal responsibility system. This is even more so in a facility such as this that falls under the health care regulations. Employers must, in consultation with the JHSC, prepare policies and programs in writing specific to the prevention of workplace violence, train workers and implement the policies in the workplace. All policies/programs relating to worker protection, including those specific to workplace violence must be reviewed annually. Recent court decisions from the health care sector reflect a very high standard to which employers are held in terms of the employer duty to take reasonable precautions to protect workers from violence.

This workplace and its 170 workers are owned and employed by the City of Kawartha Lakes (CKL). The situation is somewhat complicated however as the employer has contracted the oversight of operations to another provider.

Policies within the workplace were reviewed during this inspection including those of the employer (CKL) and the management company.

Recipient	Inspector Data	Worker Representative
Name Pamela Kulas	**MICHAEL BENEDICT** OCCUPATIONAL HEALTH & SAFETY INSPECTOR PROVINCIAL OFFENCES OFFICER 300 Water St 3rd Flr, Peterborough ON K9J 8M5 HSPeterboroughDistrict@ontario.ca **Tel: (705) 755-4711** **Fax: (705) 755-4724**	Name Miranda Attelaar
Title Administrator		Title Worker Rep
Signature	Signature	Signature Miranda Attelaar

You are required under the Occupational Health and Safety Act to post a copy of this report in a conspicuous place at the workplace and provide a copy to the health and safety representative or the joint health and safety committee if any. Failure to comply with an order, decision or requirement of an inspector is an offence under Section 66 of the Occupational Health and Safety Act. You have the right to appeal any order or decision within 30 days of the date of the order issued and to request suspension of the order or decision by filing your appeal and request in writing on the appropriate forms with the Ontario Labour Relations Board, 505 University Ave., 2nd Floor, Toronto, Ontario M5G 2P1. You may also contact the Board by phone at (416) 326-7500 or 1-877-339-3335 (toll free), mail or by website at http://www.olrb.gov.on.ca/english/homepage.htm for more information.

OHS Case ID: **02776LCQN159**
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Workplace Identification: **VICTORIA MANOR** Notice ID:
220 ANGELINE STREET SOUTH, LINDSAY, ON, CANADA K9V 4R2

A electronic suite of training materials for workers is provided to workers and most elements are required to be refreshed annually including those relating to workplace violence prevention. Members of the JHSC indicated that policies are brought to the JHSC for discussion and are reviewed annually as required. A brief risk assessment is also conducted annually by members of the JHSC. This risk assessment predominantly focuses on the physical condition of the workplace.

New workers complete the suite of training materials immediately upon being hired. Existing workers complete training as time permits with reminders from their supervisors. Workers report that there is frequently insufficient time to complete these modules which is reflected somewhat in the training records. It does appear that although some staff have not completed training in the past year, most have done the training at least once over the past 3 years.

The policy specific to workplace violence that was prepared by the employer (CKL) that was available during this inspection had a review date of 2013 and no recent training of workers in it's contents has been provided. Because this requirement for policy and program development is on the employer, and the employer is the City of Kawartha Lakes, this duplication or redundancy of programs might reasonably be confusing to workers and difficult to follow as each contain disparate elements. 1 order has been issued.

As this a unionized workplace one of the complainants has been advised to work with their union with regard to their reprisal allegation.

It has been put forward by a number of workers, including the worker member of the JHSC, that workers fear reprisal from the employer for bringing forward safety concerns. This includes those relating to workplace violence. The worker member expressed a belief that as many as 40 events might be occurring monthly where employer records put it somewhere between 10-15. Whether the number is 40 or 15 is not significant. Any number greater than 0 should prompt continual efforts to improve.

The employer has done a number of things including the establishment of a team of experts to establish individual plans of care for residents identified as having a potential for violence.

Whether reprisal occurring a realistic fear or not, the worker perception that it could occur is something that the employer should examine very seriously. A healthy, effective internal responsibility system requires the participation of all of the workplace parties and cannot exist in an environment where workers do not feel safe from reprisal.

Workers are reminded that in order for the employer (or the Ministry) to effectively identify unsafe situations in the workplace workers must report unsafe working conditions including events or near events of workplace violence.

Recipient	Inspector Data	Worker Representative
Name _____	**MICHAEL BENEDICT** OCCUPATIONAL HEALTH & SAFETY INSPECTOR PROVINCIAL OFFENCES OFFICER 300 Water St 3rd Flr, Peterborough ON K9J 8M5 HSPeterboroughDistrict@ontario.ca **Tel: (705) 755-4711** **Fax: (705) 755-4724**	Name _____
Title _____		Title _____
Signature	Signature	Signature

You are required under the Occupational Health and Safety Act to post a copy of this report in a conspicuous place at the workplace and provide a copy to the health and safety representative or the joint health and safety committee if any. Failure to comply with an order, decision or requirement of an inspector is an offence under Section 66 of the Occupational Health and Safety Act. You have the right to appeal any order or decision within 30 days of the date of the order issued and to request suspension of the order or decision by filing your appeal and request in writing on the appropriate forms with the Ontario Labour Relations Board, 505 University Ave., 2nd Floor, Toronto, Ontario M5G 2P1. You may also contact the Board by phone at (416) 326-7500 or 1-877-339-3335 (toll free), mail or by website at http://www.olrb.gov.on.ca/english/homepage.htm for more information.

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Recipient	Inspector Data	Worker Representative
Name _____	**MICHAEL BENEDICT** OCCUPATIONAL HEALTH & SAFETY INSPECTOR PROVINCIAL OFFENCES OFFICER 300 Water St 3rd Flr, Peterborough ON K9J 8M5 HSPeterboroughDistrict@ontario.ca **Tel: (705) 755-4711** **Fax: (705) 755-4724**	Name _____
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Workplace Identification: **VICTORIA MANOR** Notice ID:
220 ANGELINE STREET SOUTH, LINDSAY, ON, CANADA K9V 4R2

Order(s) /Requirement(s) Issued To:

To: **CORP OF THE CITY OF KAWARTHA LAKES, THE**
Org/Ind Role: **Primary Employer**

Mailing Address:
180 KENT ST WEST, LINDSAY, ON, CANADA K9V 2Y6

Order(s) /Requirement(s) Description:
You are required to comply with the order(s) /requirement(s) by the dates listed below.

No	Type Code	ActReg	Year	Sec.	Sub Sec.	Clause	Text of Order/Requirement	Comply by Date
1 02776LCQN161	Time	OHSA 67	1990 1993	9	2		**The employer shall review and revise the measures and procedures for the protection of workers specific to workplace violence. At the time of this inspection the employer policy with regard to workplace violence was last reviewed in 2013.**	**2017-FEB-17**

Recipient	Inspector Data	Worker Representative
Name _____	**MICHAEL BENEDICT** OCCUPATIONAL HEALTH & SAFETY INSPECTOR PROVINCIAL OFFENCES OFFICER 300 Water St 3rd Flr, Peterborough ON K9J 8M5 HSPeterboroughDistrict@ontario.ca **Tel: (705) 755-4711** **Fax: (705) 755-4724**	Name _____
Title _____		Title _____
Signature	Signature	Signature

You are required under the Occupational Health and Safety Act to post a copy of this report in a conspicuous place at the workplace and provide a copy to the health and safety representative or the joint health and safety committee if any. Failure to comply with an order, decision or requirement of an inspector is an offence under Section 66 of the Occupational Health and Safety Act. You have the right to appeal any order or decision within 30 days of the date of the order issued and to request suspension of the order or decision by filing your appeal and request in writing on the appropriate forms with the Ontario Labour Relations Board, 505 University Ave., 2nd Floor, Toronto, Ontario M5G 2P1. You may also contact the Board by phone at (416) 326-7500 or 1-877-339-3335 (toll free), mail or by website at http://www.olrb.gov.on.ca/english/homepage.htm for more information.

Ministry of Labour **Safe At Work Ontario**

Operations Division | Occupational Health and Safety

Return To:
MICHAEL BENEDICT
OCCUPATIONAL HEALTH & SAFETY INSPECTOR
PROVINCIAL OFFENCES OFFICER
300 Water St 3rd Flr, Peterborough ON K9J 8M5
HSPeterboroughDistrict@ontario.ca
Tel: (705) 755-4711
Fax: (705) 755-4724

Ontario

Notice of Compliance

OHS Case ID: **02776LCQN159**
Field Visit No: **02776LCQN160**

Visit Date : **2017-FEB-01**

Workplace Identification: **VICTORIA MANOR**
220 ANGELINE STREET SOUTH, LINDSAY, ON, CANADA K9V 4R2

Notice ID:

Take Notice

Orders were issued under the authority of the Occupational Health and Safety Act or Regulations made there under. A notice of compliance shall be submittec to the Ministry of Labour within three days after the Constructor or Employer believes that compliance with the Order(s) / Requirement(s) have been achieved.

Order(s) / Requirement(s) Issued:

To:
CORP OF THE CITY OF KAWARTHA LAKES, THE

Role
Primary Employer

Mailing Address:
180 KENT ST WEST, LINDSAY, ON, CANADA K9V 2Y6

Order(s) / Requirement(s) Description:
You are required to comply with the Order(s) / Requirement(s) by the Comply by Dates listed below.

No.	Type Code	ActReg	Year	Sec.	Sub Sec.	Clause	Compliance Details / Date	JHSC Worker Member / Worker Representative	Comply by Date:
1 02776LCQN161	**Time**	**OHSA** **67**	**1990** **1993**	**9**	**2**		Feb 16/17 (attached letter)	☑ Agree ☐ Disagree Miranda Attelaar Feb 16/17 (Signature) Janey Coons Feb 16/17	**2017-FEB-17**

Form completed by: Janey Coons

Title: Human Resources Generalist

For / on behalf of JCOMP

Signature:

Joint Health and Safety Committee Member representing workers or Worker Representative agrees or disagrees that compliance has been achieved with all the Order(s) as indicated above.

Name: Miranda Attelaar

Signature: (absent)

You are required under the Occupational Health and Safety Act to post a copy of this report in a conspicuous place at the workplace and provide a copy to the health and safety representative or the joint health and safety committee if any. Failure to comply with an order, decision or requirement of an inspector is an offence under Section 66 of the Occupational Health and Safety Act. You have the right to appeal any order or decision within 30 days of the date of the order issued and to request suspension of the order or decision by filing your appeal and request in writing on the appropriate forms with the Ontario Labour Relations Board, 505 University Ave., 2nd Floor, Toronto, Ontario M5G 2P1. You may also contact the Board by phone at (416) 326-7500 or 1-877-339-3335 (toll free), mail or by website at http://www.olrb.gov.on.ca/english/homepage.htm for more information.

THE CORPORATION OF THE CITY OF KAWARTHA LAKES

Health & Social Services Department
M E M O R A N D U M

TO: **Victoria Manor Committee of Management**
FROM: **Pamela Kulas, Administrator**
DATE: **April 24, 2017**
RE: ***Resident Quality Inspection Report – Ministry of Health***

A Ministry of Health Inspection was conducted the Resident Quality Inspection on February 21 to 24, 27-28 and March 1-3, 2017. During the inspection the following inspection protocols were used: Accommodation Services – Maintenance; Continence Care and Bowel Management; Dignity, Choice and Privacy; Dining Observation; Falls Prevention; Family Council; Hospitalization and Change in Condition; Medication; Minimizing of Restraining; Nutrition and Hydration; Personal Support Services; Prevention of Abuse, Neglect and Retaliation; Reporting and Complaints; Resident's Council; Responsive Behaviours; Safe and Secure Home; Skin and Wound Care; Sufficient Staffing.

During the course of the inspection the home received 10 Written Notices and 6 Voluntary Plans of Correction.

Glossary of Findings: In order of severity from lowest to highest

Finding Type	Short Form	Interpretation
Written Notice	WN	Evidence that not all information was found readily available as per the regulation
Voluntary Plan of Correction	VPC	It is recommended that a plan of action be put in place to ensure sustained follow up
Compliance Order	CO	The inspection found the regulation had not been followed
Directors Referral	DR	Sustained non compliance is found and the Director of the Performance, Compliance and Inspection Branch (MOHLTC) will review the Home's record
Work and Activity Order	WAO	Ministry staff will be on site regularly to ensure safe operations of the Home

To summarize findings:

1. **Care plans need to be up to date and staff are required to follow care plans at all times.**
    i. Corrective Actions:
        i. Process in place to ensure care plans are reviewed and updated
        ii. Staff received education on the importance of following care plans
        iii. Staff are required to sign a tracking sheet confirming the review of a care plan once updated
        iv. Auditing of care plans in place

2. **Reporting of abuse and neglect, suspected or actual needs to occur immediately and investigated.**
    i. Corrective Actions:
        i. Education provided to staff on reporting requirements
        ii. All staff acknowledged receipt of the policies on abuse and neglect
        iii. All staff received abuse and neglect education

3. **Call bell response time.**
    i. Corrective Actions:
        i. Education provided to all staff on call bell response
        ii. Call bell volume adjusted to ring at maximum volume at all times
        iii. Portable telephone system being installed in 2017

4. **Residents who require a restraint must be assessed, monitored and care plan must be updated.**
        i. Audits for all residents using restraints complete
        ii. Care plans of those residents identified have been updated
        iii. Education provided to Registered staff on alternatives to restraints
        iv. Restraint lead has been assigned

5. **Staffing plans for nursing and personal support must be in place and evaluated annually.**
    i. Corrective Actions:
        i. Staffing plans have been evaluated
        ii. Staffing contingency plans have been updated
        iii. Staffing compliment reports will be reviewed with additional supports put into place when required

6. **Hand hygiene audits need to be completed.**
    i. Corrective Actions;
        i. Hand hygiene audit app will be purchased
        ii. Hand hygiene audits will be scheduled and completed as per schedule
        iii. Completion of hand hygiene audits will be monitored

7. **A copy of written complaints shall be sent to the Ministry of Health.**
    i. Corrective Actions:
        i. Leadership team and Registered staff will be educated on complaint policies and procedures
        ii. All emails received from family members will be forwarded to the Administrator for review and follow up
        iii. Trending of complaints will be reviewed at quarterly Leadership and Quality meetings with action plans developed as required

8. **Residents who require a PASD must be assessed, monitored and care plan must be updated.**
        i. Audits for all residents using PASD will be completed
        ii. Care plans of those residents identified will be updated
        iii. Education provided to Registered staff

9. **Verbal and written complaints shall be investigated and resolved within 10 business days.**
    i. Corrective Actions:
        i. Leadership team and Registered staff will be educated on complaint policies and procedures
        ii. Complaint record form will be implemented
        iii. Complaints will be logged and tracked

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Ministry of Health and Long-Term Care

Ottawa Service Area Office
Long-Term Care Inspections Branch
Long-Term Care Homes Division
347 Preston Street, 4th Floor, Suite 420
Ottawa ON K1S 3J4

Ministère de la Santé et des Soins de longue durée

Bureau régional de services d'Ottawa
Inspection de soins de longue durée
Division des foyers de soins de longue durée
347, rue Preston, 4iém étage, bureau 420
Ottawa ON K1S 3J4

Ontario

Telephone/Téléphone: 613-569-5602
Toll Free/Sans frais 1-877-779-5559
Fax/Télécopieur: 613-569-9670

Date: April 10, 2017

To: Administrator
Victoria Manor Home for the Aged
President, Residents' Council
President, Family Council

Re: **Inspection #:** 2017_594624_0003
Report Date: March 27, 2017
Type of Inspection: Resident Quality Inspection

Enclosed is an ***Inspection Report - Public Copy*** for an inspection conducted under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

Individual envelopes addressed to the 'President, Residents' Council', and 'President, Family Council', must be distributed, unopened to the addressee.

This ***Inspection Report – Public Copy*** must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2). A copy of the ***Inspection Report-Public Copy*** must be made available without charge upon request.

The report will also be on file with the Service Area Office, Long-Term Care Inspections Branch, and posted on the Long-Term Care Homes.net website

http://publicreporting.ltchomes.net/en-ca/default.aspx

RECEIVED Apr. 11/17

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
Mar 27, 2017	2017_594624_0003	000675-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF KAWARTHA LAKES
26 Francis Streeet LINDSAY ON K9V 5R8

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

VICTORIA MANOR HOME FOR THE AGED
220 ANGELINE STREET SOUTH LINDSAY ON K9V 4R2

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

BAIYE OROCK (624), CRISTINA MONTOYA (461), JENNIFER BATTEN (672), KARYN WOOD (601), LYNDA BROWN (111)

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

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

This inspection was conducted on the following date(s): February 21, 22, 23, 24, 27, & 28, March 1, 2, & 3, 2017

During the RQI the following Critical Incident Logs were inspected concurrently:
Re: Alleged resident to resident abuse and responsive behaviours - 023581-16, 027099-16, 027411-16, 028033-16, 028358-16, 030191-16, 031469-16, 032012-16,
Re: Alleged resident neglect and/or abuse - 016835-16, 023356-16, 025899-16, 026105-16, 029614-16, 001079-17, 003232-17,
Re: Falls - 027963-16, 030241-16, and 030265-16.

In addition, the following complaint logs were inspected:
001444-17 (re: resident care), 001727-17(re: responsive behaviors), and 017526-16 (re: food and dietary concerns)

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Environmental Service Manager, the Manager of Dietary Services, the Manager for Resident and Family Services, the Physiotherapist, Bahavioral Support Ontario (BSO) workers, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, Laundry Aides, the presidents of Residents' and Family Council, residents and family members.

A tour of the home was carried out, an observation of medication administration, several meal services, staff to resident and resident to resident interactions was made. A review was also completed of residents' health records, the Licensee's internal investigations and relevant policies and procedures related to zero tolerance of abuse, falls, responsive behaviors and complaint process.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
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
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.
10 WN(s)
6 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care that sets out clear directions to staff and others who provide direct care to resident #013 related to the use of bed rails.

On a specified date and time, resident #013 was observed by Inspector #461 to be lying down in bed with one-quarter bed side rail in the up position.

A review of resident #013's health care records indicated that the resident's cognitive skills for daily decision making was severely impaired and required a special behaviour symptom evaluation. The care plan indicated that resident #013 had responsive behaviors and required two-staff to assist with all transfers. The written care plan did not identify interventions related to the use of bed side rails.

In interviews conducted on specified dates with PSW #135, RPNs #153 & #154 by Inspector #461 about the use of bed rail for resident #013, the PSW indicated that resident #013 used the bed rail for positioning, and for safety. RPNs #153 and #154 indicated to Inspector #461 that they did not know the resident was using a bed side rail, but assumed that it was probably used for positioning and safety.

In an interview with the DOC on a specified date by Inspector #461, the DOC indicated that resident #013's Substitute Decision Maker (SDM) was notified about the use of bed rail for positioning and safety. The DOC reported that the paperwork was ready to be signed and the care plan was pending to be updated. However, the DOC acknowledged that presently the resident's care plan was not updated to indicate the use of the bed rail

even though the staff were currently using it.

After observations, review of health records, and interviews with the staff; it was determined that the plan of care of resident #013 did not include the use of bed side rail to assist resident with transferring and promote safety. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the written plan of care for resident #017, related to personal care, set out clear directions to staff and others who provide direct care to the resident.

According to the health care records of resident #017, the resident is totally dependent on staff for provision of personal care. On a several occasions and on different specified dates and times, Inspector #672 observed resident #017 not receiving the personal care the resident was to receive from staff. In interviews conducted on several specified dates and times with PSW #137, RPN#126 and RPN#152, related to the personal care the resident was to receive, all three staff members indicated that the personal care was not provided as resident had responsive behaviors and would not allow care to be provided. Both RPNs, who reported they were responsible for updating resident's #017's care plan, indicated that the Physician was not made aware of the said behaviors and no interventions have been put in place to manage those behaviors. The RPNs went further to indicate that those behaviors should be listed in the resident's plan of care to provide directions to PSW staff who provide direct care to the resident.

A review of resident #017's most recent care plan at the time of the inspection by Inspector #672, revealed that there were no goals or interventions listed in regards to resident #017's personal care and behaviors.

The licensee failed to ensure that the written plan of care for resident #017 set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to resident #043 as specified in the plan, related to falls risk.

Related to log # 026105-16,

A Critical Incident Report was submitted to the Director on a specified date for an alleged staff to resident neglect incident . As per the CIR, resident #043's call bell was activated at a specified time and was not responded to for over an hour.

A review of the written care plan for resident #043 (in place at time of incident) indicated that the resident was at risk for falls related to history of falls/injury, impaired mobility, gait disturbance, and other related medical diagnoses, with specified interventions to be followed by staff to prevent falls.

The care set out in the plan of care was not provided to the resident as the resident's call bell was activated and staff took over an hour to respond which resulted in a risk to the resident. [s. 6. (7)]

4. Related to log # 023356-16,

A Critical Incident Report was submitted to the Director on a specified date for an allegation of staff to resident neglect. The CIR indicated that on a specified date and time, resident #042 was found by PSW #131 & #132 lying in bed in a prolonged position that resulted in injury.

The CIR indicated that though there were interventions in place at the time of the incident, PSW #133 had failed to follow the home's policy on checking and repositioning of the resident while the resident was in bed. PSW received disciplinary actions.

In an interview with the DOC on a specified date, she indicated that PSW #133 had placed the resident into bed at at a specified time with assistance from PSW #138. The DOC indicated that resident #042 should have been checked every hour and repositioned every 2 hours due to the applied interventions in place at the time. The DOC indicated that PSW #133 had failed to follow the policy on checking and repositioning the resident.

Review of health record for resident #042 indicated the resident was no longer in the home. The written plan of care (in place at time of incident) indicated that the resident was to be turned and repositioned every two hours while in bed as resident was unable to perform turning and repositioning independently.

The care set out in the plan of care was not provided to resident #042 as the resident was not repositioned on the identified date and time as per the written plan of care and resulted in injuries. [s. 6. (7)]

5. The Licensee has failed to ensure that the care set out in the plan of care for resident

#060 was provided to the resident as specified in the plan related to responsive behaviours.

Related to log #001079-17,

On a specified date and time, the ADOC contacted the Ministry of Health and Long Term Care (MOHLTC) to report a Critical Incident Report (CIR) related to an alleged staff to resident verbal abuse that occurred on another specified date and time.

According to the submitted CIR, on a specified date and time, RPN #113 submitted a written statement to the DOC indicating that PSW #111 spoke to resident #060 in a loud voice while redirecting resident #060 from the room of resident #061. During the encounter with PSW #111 and resident #060, resident #060 became agitated as a result of the manner in which the resident was addressed by the PSW, attempted to push the PSW. The PSW in return became upset and yelled at the resident, causing the resident to swing at the PSW, hitting the PSW to the face. PSW #113, according to the written statement is reported to have threatened the resident by indicating that the police should be called.

According to the same CIR, approximately half an hour following the incident, resident #060 approached PSW #114. PSW #114 stepped back from resident #060 and loudly indicated that resident #060 did not get to talk to him/her because the resident had hurt people that he/she worked with and then PSW #114 stormed off.

A review of resident #060's clinical health records by Inspector #601 on a specified date indicated that resident #060 had difficulty expressing emotions as well as other responsive behaviors. Interventions in place at the time of the incident to deal with the resident included among others: to allow the resident enough time to express self, provide reassurance and try not to talk over the resident, and staff are to leave the situation and re-approach if resident is unable to calm down.

The care set out in the plan of care for resident #060 was not provided to resident #060 as specified in the plan related to the management of responsive behaviours when approached by staff for redirection on the identified date. [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
(1) the care plan provides clear direction to staff who provide direct care to resident for
(a) resident #013 regarding the use of bed side rail, (b) resident #017 regarding provision of personal care,
(2) the care set out in the plan of care is provided to resident as specified in the plan for
(a) resident #043 regarding timely response to resident's call bells,
(b) every resident requiring frequent checks and repositioning, is checked and repositioned as specified in their plan,
(c) resident #060 regarding management of responsive behaviors, 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 that uses sound to alert staff, was properly calibrated so that the level of sound was audible to staff.

The Long-Term Care Home is equipped with a resident-staff communication and response system that uses sound to alert staff which allows calls to be cancelled only at the point of activation. The communication system also uses a visual, ceiling-mounted display marquis down the center of each hallway that when activated, indicates where the signal is coming from.

Related to log # 025899-16,

A Critical Incident Report was submitted to the Director on a specified date which indicated that the Director was notified of an alleged staff to resident neglect incident that occurred on the same day. The CIR indicated that resident #036 was found on the floor in the resident`s room. The CIR indicated that the resident had rang the call bell at a specified time to go to the bathroom and then attempted to toilet self and fell to the floor. The resident was "visibly upset" and sustained an injury. The CIR indicated that night staff PSWs did not hear the call bell due to the bell being put at "night setting" and day

staff PSWs arrived at 0630 hours, heard the call bell but did not respond as they were receiving report. The day PSW (#117) then proceeded to answer the call bell about 30minutes after it was activated, and found the resident on the floor.

Interview with the Administrator indicated that resident #036 had rang the call bell on the said date and it was not answered for a period of 30 minutes. The Administrator indicated that staff have been instructed to respond to call bells in a timely manner and not to turn down the call bell volume.

In interviews with RPN #103 and RPN #118 on two resident home areas by Inspector #111, both indicated that they turn down call bell volume to "night" mode on afternoon and night shift as the volume is too loud at the nursing station. RPN # 102 on a third resident home area indicated they have the ability to turn the call bell system volume down but day shift does not.

Interview with the Environmental Service Manager (ESM) by Inspector #111 and observation indicated that when the call bell system is turned to night mode, the call bells were not audible in the back hall or in residents' rooms or in tub/shower rooms. [s. 17. (1) (g)]

2. Related to log # 026105-16,

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 that resident #043's call bell was activated on an specific date and was not responded to for over an hour. The CIR indicated no negative effect on the resident.

According to the same CIR, "the call bell volume was set at night setting making it difficult to hear above the volume of bed alarms and chair alarms" and the night PSWs did not recall hearing the call bell. [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 is calibrated to a sound level that is audible to staff from all areas of the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During an interview with resident #037, by Inspector #111, the resident had indicated an allegation of staff to resident abuse and neglect and indicated ongoing complaints related to care not being provided.

Review of the progress notes for resident #037 indicated on a specified date and time,

the resident reported to RPN #141 regarding a PSW. The resident indicated the PSW had refused to provide requested assistance and told the resident to perform the requested task independently. The resident reported feeling really upset and refused any further care from the PSW. The resident also reported that the PSW unintentionally hit the resident's legs with the lift resulting in pain and that PSW then denied hitting the resident with the lift. The resident stated being upset with the PSW's tone and indicated "it was very rude". The resident had requested to speak to a RN regarding the incident.

Interview with DOC and ADOC by Inspector #111, indicated that RPN #141 had reported the allegation to RN #156 on a specified date. However, the RN did not immediately investigate the allegation. [s. 23. (1) (a)]

2. The Licensee failed to ensure that appropriate action is taken in response to every incident of alleged, suspected or witnessed abuse or neglect that the licensee knows of, or that is reported to the licensee.

Related to log #026105-16,

A Critical Incident Report indicated that the Director was notified on a specified date of an alleged staff to resident neglect incident with no negative outcome to the resident.

Interview with the Administrator by Inspector #111 indicated that resident #036 rang the call bell on a specified date and staff did not respond for a period of 30 minutes leading to a fall of the resident resulting in an injury. The Administrator indicated the two night shift PSWs failed to respond to the call bell in a timely manner and received re-education. The Administrator indicated the outcome of the investigation was unfounded as there was no intent to neglect the resident by the night staff.

Review of the home's investigation indicated:
- PSW # 119, 120 & RPN #121 were working on the unit when the call bell for resident #036 & #043 was activated and did not respond to the call bells. All three staff ended their night shift without responding to the call bells. PSW #119 & #120 indicated they did not hear resident #036 call bell as they were assisting another resident. RPN # 121 was an agency staff and no longer works in the home, but was not interviewed at the time.

-PSW #117, #122, #123 & #124 & RPN #103 who replaced PSW # 119, 120 & RPN #121, recalled hearing the call bells ringing but proceeded to attending the shift change report. Approximately an hour later, PSW#117 proceeded to answer the call bell of

resident #036 and found the resident on the floor in bathroom. The resident was "visibly upset" and stated the call bell had been "ringing for 50 minutes!" . RN #125 assessed the resident and indicated "reviewed neglect algorithm and felt it was neglect". Resident #043 call bell was then answered following discovering the roommate (resident #036 on the floor).
-the investigation also determined that on a specified night shift, resident #043 had rang their call bell and it rang for over an hour. In addition, resident #041 had rang their call bell and the call bell rang for over 26 minutes on the same shift. There was no CIR submitted for this resident.

The only action taken by the home to prevent a recurrence was to re-educate all staff on responding to call bells in a timely manner and occurred after a call bell audit indicated more than one resident had not had their call bells answered in a timely manner. All staff involved in the incidents did not receive the re-training. There was no other actions taken despite the home's investigation indicating that staff were turning the call bell volume down, the call bell audit indicating that several staff failed to respond to the residents call bells, and one resident fell, was upset and sustained an injury as a result which constituted neglect. [s. 23. (1) (b)]

Additional Required Actions:

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

WN #4: 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 when a person 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, has occurred or may occur, they are to immediately reported the suspicion and the information upon which it was based to the Director.

According to Ontario Regulations (O. Reg.) 79/10, s. 2 (1), "verbal abuse" means 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.

During an interview with resident #037, by Inspector #111, the resident had indicated an allegation of staff to resident abuse and neglect and indicated having ongoing complaints related to care not provided.

Review of the progress notes for resident #037 indicated on a specified date and time, the resident reported to RPN #141 regarding a PSW. The resident indicated the PSW had refused to provide requested assistance and told the resident to perform the requested task independently. The resident reported feeling really upset and refused any further care from the PSW. The resident also reported that the PSW unintentionally hit the resident's legs with the lift resulting in pain and that PSW then denied hitting the resident with the lift. The resident stated being upset with the PSW's tone and indicated "it was very rude". The resident had requested to speak to RN regarding the incident.

Interview with DOC and ADOC by Inspector #111, indicated RPN #141 had reported the allegation to RN #156 on a specified date but the RN did not immediately report the allegation 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 the abuse or neglect of a resident has occurred or may occur, shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: 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 failed to ensure that the staffing plan was evaluated and updated at least annually.

Based on WN #7 related to the organized program of personal support services, WN #2 related to issues with the communication and response system in the home, and a complaint from a family member related to staffing issues in the home, the staffing plan of the home was reviewed. The reviewed evaluated plan for 2016, done in September of 2016 (for period September 2015 - September 2016) did not have any summary of changes made to the plan and when those changes were implemented. There was also no record of a staffing plan being evaluated in 2014 and 2015.

During an interview with the Administrator on a specified date, she indicated that an evaluation of the staffing plan was not completed in 2014 and 2015 and as as such, no record exists for those two years. [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 to ensure that the staffing plan is evaluated and updated annually with a summary of the changes made to the plan and the date that those changes were implemented related to staffing mix, to be implemented voluntarily.

WN #6: 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 specifically related to hand hygiene practices when handling food and fluids.

On a specified date, Inspector #672 observed RPN #103 assisting resident #021 on two occasions with a supplement intake. The Inspector noted that the resident took a small amount of supplement, and RPN #103 returned to the computer at the desk. RPN did not perform hand hygiene prior to or following assisting the resident.

On another specified date and time, during the lunch dining observation on a resident home area, Inspector #672 observed Dietary Aide #106 adding the Gherkin pickles to each resident's plate using his/her bare hands while handling other food items and performing other tasks. Hand hygiene was not performed between the different tasks and/or reaching in to the Gherkin pickle dish. On the same day and meal service, Inspector #672 also observed that PSW #109 was removing dirty soup bowls from the dining tables, then serving the main meals without performing hand hygiene. PSWs #107, #108, and #109, were also observed providing residents assistance with their meals, but not performing hand hygiene between residents. Four days later and in the same resident home area, during the lunch meal service, Inspector #461 observed that PSW #160 was serving the soup to residents while pushing the serving cart and checking the diet list binder without performing hand hygiene between tasks. Inspector also observed PSW #160 serving soda crackers using a tong, but instead of placing them on the resident's plate or soup, he/she put the crackers on his/her bare hands, crush them and sprinkle them onto the residents' soups. He/she continued pushing the serving cart and touching the diet list without washing his/her hands when transitioning from dirty to clean tasks.

On yet another specified day, Inspector #672 observed on a different home area that PSW #143 was administering the afternoon nourishment without performing hand hygiene between residents, even though PSW #143 was assisting some residents with their snack and/or fluids, and assisted one resident back to a chair in the lounge area, and moved another resident sitting in a wheelchair. Eight and nine days later and in the same home area Inspector #672 observed PSWs #142 and #144 administering the afternoon nourishment without performing hand hygiene during the pass. PSW #144 provided assistance to two residents, one in the lounge area, and one in the TV room, then returned to the nourishment cart, and continued with administering snacks without performing hand hygiene. The following day, PSW #142 was observed assisting two separate residents, as one of the residents was pushing another resident in a wheelchair. When the PSW #142 returned to the nourishment cart, he/she did not perform hand hygiene prior to administering the snack and fluids to the other residents in the lounge area.

Review of the Home's LTC Infection Prevention & Control policy #IC-G10.10 related to hand hygiene, last revised on April 2016, indicated that all team members and volunteers will practice hand hygiene to reduce the spread of infections, and that some practices included: hand hygiene before handling/consuming food or drink, after contact with body substances or specimens, contaminated or soiled items (laundry, waste, equipment).

In interviews with the Manager of Dietary Services, the DOC and ADOC regarding the home's expectations related to food handling practices during dining and snack services, all indicated that staff are expected to wash their hands when transitioning from dirty to clean surfaces or tasks, when going in and out of the dining room, prior to starting the snack cart and when stopping to assist someone as well as before and after assisting residents during meal and snack services.

Based on the observations, review of the home's hand hygiene policy, and interviews with the DOC, ADOC, and Manager of Dietary Services, the Licensee failed to ensure that staff participate in the implementation of the infection prevention and control program. [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 all staff participate in the implementation of the infection prevention and control program specifically related to hand hygiene practices when handling food and fluids, to be implemented voluntarily.

WN #7: 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 :

1. The Licensee has failed to ensure that the organized program of personal support services for the home, met the assessed needs of resident #069.

On a specified date and time a complaint was received by Inspector #624 from a family member who reported that due to staffing issues in the home, the complainant's family member's calls for assistance are not responded to in a timely manner leading to numerous complaints from the resident whenever the complainant visits. The complainant also indicated that he/she finds that his/her mother's clothing are wet with urine when being laundered.

On two consecutive dates, Inspector #624 interviewed resident #068 and #069 who are roommates. Both residents were alert, oriented, and cognitively well. Resident #069 needs total assistance for personal care. On a specified day, resident #068 reported to Inspector #624 that resident #069, had to wait for over an hour to be provided personal care. Resident #068 also indicated that there have been several occasions where resident #069 had to wait a really long time before receiving assistance from staff especially when staff are "working short".

In an interview with resident #069 on a specified date and time, the resident reported to Inspector #624 that there have been numerous occasions when the resident had rang the call bell and waited "too long" before being assisted. On one occasion, according to the resident,the resident had to wait for over an hour to be assisted with personal care. On another occasion, the resident reported having no choice but to accept substitution of a method of care provision as staff were "working short."

On a specified date and time, PSW #152 and RPN #137, working in the resident home area were resident #069 resides, were interviewed by Inspector #624 and both indicated that they "work short" on the home area most of the time and when that happens, residents don't get toileted as often as they should, sometimes full baths are replaced with bed baths, residents get put to bed late and call bells don't get responded to in a timely manner.

A review of Normal Staffing Compliment section of the PSW Staffing Contingency Plan for the identified resident home area indicated that during the day shift (0630 – 1430), and the evening shift (1430 – 2230) there are four PSWs on duty and assigned to provide resident care, with one of the evening PSWs working 4.5 hours.

A review of a calendar kept in the nursing station, showed to Inspector #624 by PSW #152 indicated that for a specified month and year, in the identified resident home area where resident #069 resides, PSW worked one less than the normal staffing complement on 15 days of the month, which included 18 shifts not covered. A review of the Weekly Detail Complementary Report provided by the Home indicated that for the same month and in the same resident home area, staff worked one less than the normal staffing complement on 15 different days of the month.

A review of the call bell report audit for the said month and for the same resident home area indicated that on six separate days and on seven different occasions, mostly when PSWs were working one less than the normal staffing compliment, the call bell of resident #069 rang for 19 - 37 minutes before it was responded to.

During an interview with the Administrator on a specified date, she indicated that whenever someone calls in sick, they follow the Lincensee's staffing contingency plan and if unsuccessful, staff are reassigned around the home based on the needs of the residents in the different home areas.

The licensee failed to ensure that the organized program of personal support services for the home, met the assessed needs of resident #069. [s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee has failed to ensure that its written policy that promotes zero tolerance of abuse and neglect of residents was complied with for resident #059 and #060.

A review of the Licensee's Prevention of Abuse and Neglect of a Resident policy number V11-G-10-00 dated January 2015 was completed by Inspector #601. The policy indicated under procedure: if any employee or volunteer witnesses an incident, or has any knowledge of an incident, that constitutes resident abuse or neglect; all staff are responsible to immediately inform the Executive Director (ED)/Administrator and/or Charge Nurse in the home.

Related to log #029614-16,

Inspector #601 reviewed a Critical Incident Report (CIR) that was submitted to the Director on a specified date and time. The CIR indicated that on a specified date and time, resident #059's Substitute Decision Maker (SDM) reported to RPN #141 that resident #059 had called the SDM on a given date and reported that a PSW staff member had grabbed the resident's ankles while trying to put on the resident's slippers. According to resident #059's SDM, the PSW was very rude to resident #059.

An investigation was initiated and it was discovered that on a specified date and time resident #059 had reported the allegations of abuse to an unidentified staff member. The CIR indicated that resident #059 had reported that a PSW came into the resident's room at 1800 hour to get the resident up for supper. The CIR indicated that resident #059 was very upset because the PSW did not ask the resident for consent and grabbed the resident's ankles to put the resident's slippers on.

During an interview on a specified date and time RPN #140 indicated to Inspector #601 that resident #059 had described and reported a PSW that had been rough during care. RPN #140 indicated that resident #059 was not able to provide further details about the incident. During the same interview, RPN #140 indicated forgetting to notify the charge nurse of the allegations brought forward by resident #059 regarding a PSW being rough during personal care.

The Director was notified of the incident a day after the incident was reported by the resident to RPN #140.

Related to log #001079-17,

On a specified date and time, the ADOC contacted the Ministry of Health and Long Term Care (MOHLTC) to report a Critical Incident Report (CIR) related to an alleged staff to resident verbal abuse that occurred on another specified date and time.

According to the submitted CIR, on a specified date and time, RPN #113 submitted a written statement to the DOC indicating that PSW #111 spoke to resident #060 in a loud voice while redirecting resident #060 from the room of resident #061. During the encounter with PSW #111 and resident #060, resident #060 became agitated as a result of the manner in which the resident was addressed by the PSW, attempted to push the PSW. The PSW in return became upset and yelled at the resident, causing the resident to swing at the PSW, hitting the PSW to the face. PSW #113, according to the written statement is reported to have threatened the resident by indicating that the police should be called.

According to the same CIR, approximately half an hour following the incident, resident #060 approached PSW #114. PSW #114 stepped back from resident #060 and loudly indicated that resident #060 did not get to talk to him/her because the resident had hurt people that he/she worked with and then PSW #114 stormed off.

During an interview on a specified date and time, the DOC indicated to Inspector #601 that the MOHLTC was called the day after the incident occurred. According to the DOC, on the day before, RPN #113 reported to RN #156 that resident #060 had struck PSW #111 in the face and did not inform the RN about the alleged staff to resident verbal abuse until the following day. The DOC indicated that RPN #113 only submitted a written statement regarding the alleged staff to resident abuse a day after the alleged incident took place.

The DOC indicated that the written statement by RPN #113 provided a day after the alleged incident outlined a more detailed account of the alleged verbal abuse of resident #060.
The Director was notified one day after the alleged incident occured. RPN #140 and RPN #113 did not comply with the licensee's policy related to reporting of abuse. [s. 20. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD 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. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the PASD used to assist resident #017 with routine activities of daily living were included in the residents' plan of care.

Resident #017 requires total assistance by staff for transferring and mobility, with the resident needing a wheelchair as primary mode of transportation.

Multiple resident observations by Inspector #672 on several days over a one week period noted that resident #017 was tilted while in the wheelchair and not being transported. This information was verified through staff interviews with PSW #115, PSW #137, RPN #126, and RPN #152. RPN#126 and RPN#152 on a specified date indicated to Inspector #672 that resident #017 is tilted in the wheelchair as a fall prevention measure.

A review of the most recent care plan of the resident had no specific focuses/interventions related to restraints and/or PASDs. RPN #126 and RPN #152 both indicated to Inspector #672 that this information should be documented in resident #017's care plan. Inspector #672 interviewed the ADOC on a specified date and time where the ADOC indicated that the tilt wheelchair for resident #017 is considered a PASDs and should be identified in the resident's plan of care.

The Licensee failed to ensure that the resident's tilt wheelchair, as well as its use as a PASD, was included in the plan of care. [s. 33. (3)]

2. The licensee failed to ensure that the use of a PASD by resident #017 to assist with activities of daily living was approved by a physician, registered nurse, registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations.

Related to resident #017 above, a review of the resident's health records over a specified three month period revealed that there was no signed order for the resident to have a PASD in place, and there was no documentation to support that the use of the PASD was being reviewed on a regular basis. The consent form for the PASD was reviewed by Inspector #672, and was signed by the Substitute Decision Maker (SDM) on specified date and time.

The licensee failed to ensure that the use of a PASD by a resident to assist with activities of daily living was approved by a physician, registered nurse, registered practical nurse, member of the College of Occupational Therapists of Ontario, member of the College of Physiotherapists of Ontario, or any other member person provided for in the legislation. [s. 33. (4) 3.]

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).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home: is 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.

A review of the progress notes of resident #037 by Inspector #111 indicated the resident had ongoing verbal complaints over a specified seven months period regarding improper care provision by staff or care not provided. The BSO indicated the resident displayed responsive behaviors, repetitive non-health related complaints as well as health related complaints with interventions put in place to attempt a resolution to the complaints, though the complaints persisted.

The progress notes indicated that on a specified date and time the resident had a complaint of staff to resident neglect and three months later, the resident had identified several complaints to RN # 157 that was put in writing related to care not provided and to concerns about a co-resident.

Interview with ADOC on a specified date indicated she was assisting resident #037 with ongoing complaints of staff not providing proper care. The ADOC indicated that BSO was also involved related to these responsive behaviours. The ADOC indicated she meets regularly with the resident to review concerns. The ADOC indicated unawareness of the

residents complaint on the specified dates above related to staff to resident neglect but indicated the written complaints provided by RN #157 were not received until five days later as the complaints were placed under her door.

Interview of the DOC indicated no awareness of the verbal complaint received by RPN #141 on a specified date and the verbal complaints received by RN #157 three months later and that she had no documented evidence they were investigated and a response provided to the resident.

Review of the home's written and verbal complaints log for 2016 (which includes description of complaint and action taken to resolve the complaint) had no documented evidence of resident #037 ongoing, repetitive, verbal complaints related to improper care or a staff to resident abuse and neglect that was reported by resident #037 on the specified date above. There was also no documented evidence that when resident #037 provided a written list of concerns three months after the specified date, that the complaints were investigated or response provided to the resident of the outcome or what would be done to resolved the complaint. [s. 101. (1) 1.]

Issued on this 6th day of April, 2017

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

Original report signed by the inspector.

March 2017 Victoria Manor Operations Report to Committee of Management

Non-Confidential Report

Submission Date: April 24, 2017
Information for the Month of: March 2017

Financials

- With the implementation of the new City of Kawartha Lakes JDE system, financial reports for December 2016, January 2017and February 2017 will be shared as information is made available

Scorecard: Quality

1) Health Quality Ontario Quality Improvement Plan (QIP) 2017-18 signed and submitted March 31, 2017.

2) LTC: MOH Compliance Orders / Inspection Findings Summary:

Date	Purpose of Visit	WN/ VPC/ CO	Findings Summary
February 21, 2017 to March 3, 2017	Resident Quality Inspection	10 WN 6 VPC	

Scorecard: People

1) Employee Engagement Survey

- Celebrated Food Service Awareness Week
- Celebrated Program and Leisure Week

Sienna Support Services Updates

Sienna Partner Visits

- March 7 – Quality & Informatics Partner and Clinical Partner
- March 8 – Recreation & Leisure Partner
- March 20 – VP Operations

Projects, Location Events and other

- On March 16th, Administrator presented “Our Willed Future” which focused on the culture change initiatives occurring in the home. Home was selected by Schlegel Centre for Learning, Research and Innovation in Long Term Care
- Health and Wellness Fair held March 26th. Over 15 vendors presented wellness products. Many visitors from the community attended the fair.

Long Term Care Update

1. Occupancy (data since last report):

Occupancy Report	Private	Semi	Basic	Short Stay	TOTAL
Admissions (+)	0	8	2	3	13
Departures (-)	0	5	0	3	8
Discounted Private or Semi – Private Beds (under 60%)	2	0	0	0	2

2. Regulatory visits i.e. MOL, Public Health:

Visitor	Date	Drivers and Actions
Ministry of Labour	March 16, 2017	Follow up to anonymous complaint regarding violence in the workplace. Inspector indicated that no orders would be received

3. Written Complaints Summary:

Compliant	Date	Outcomes
Mail delivery process and benefits	09-Mar-2017	Resolved
Medication regime for bowels	10-Mar-2017	Resolved

4. Written Compliments Summary:

Compliment	Date	Outcomes
Family thankful for the sympathy card signed and sent by staff. Family says staff are stellar and are to be commended.	2-Mar-2017	Posted on google plus home page Posted on Kudos board
Donation given to Resident's Council in memory of resident	9-Mar-2017	Posted on Kudo's board
Card received for the wonderful care provided by staff	10-Mar-2017	Posted on Kudo's board
Resident is so happy with the care she is receiving she has declined to move to a private room closer to her family	17-Mar-2017	Posted on Kudo's board
Residents family provided home with a book in memory of their father about his life	20-Mar-2017	Posted on Kudo's board

5. OH&S Issues (as applicable):

OH & S Issue	Date	Outcomes
Violence in the workplace policy provided to all employees	27-Feb-2017	Policy provided to all employees

6. Media Issues (as applicable):

Media Issues	Date	Outcomes

No issues noted		

7. Resident & Family Satisfaction Survey (as applicable):

Resident & Family Satisfaction Survey Scores	Date	Outcomes
Family response rate 42%. Overall Family satisfaction 82%	January 27, 2017	Families are being informed about the upcoming new web site.

8. Employee engagement updates:

Update	Date	Outcomes
Leadership team is utilizing Wildly Important Goals (WIG) methodology to focus on orientation and retention	Ongoing weekly	Employees receive updates every 2 months at general staff meetings
Home specific LTC Quality Improvement Plan includes implementation of performance appraisals, increasing membership in the QWL committee, planning one fun event each month,	Ongoing	

9. External vacancies and hires:

Position	PT External Vacancies	TPT External Vacancies	PT External Hires	TPT External Hires	Current Status
RN	1	0	0	0	Interviews in progress
RPN	0	0	0	0	All positions have been filled
PSW	1	1	1	6	Job fair held February 22, 2017

Building Services	0	0	0	0	All positions have been filled
Dietary Aide	0	0	0	0	All positions have been filled
Life Enrichment	0	0	0	0	All positions have been filled
Reception	0	1	0	0	Reference checks in process

10. Any updates re Resident/Family Councils:

Council	Date	Outcomes/ Comments
Family Council held meeting	March, 2017	Satisfaction Survey results shared.

11. Any contract updates i.e. Pharmacy Services / TENA / etc.:

Contracts	Date	Outcomes/ Comments
Nothing to report		

12. List all outstanding building, legal / insurance claims issues:

Council	Date	Outcomes/ Comments
Nothing to report		

13. Capital Expenses:

Issue & date	Total Spent @ 03/31/17	Approved Budget
Heating & Cooling System 1st floor dining rooms and serveries	$8,242	$ 22,500
HVAC Units		$ 56,000
Ascom Telephone System	In progress	$ 55,000

MacMillan Common Area Furniture	$13,591.00	$ 15,000
Resident Café Area	Plan submitted to MOHLTC for approval	$ 6,000
Resident Room Furniture	Ordered	$ 5,000
Dining Room Tables		$ 2,500
Tub Rooms MacMillan/Elford	$40,398	$ 35,000
Automatic Door Openers – 1st floor washrooms	$4,019	$ 3,000
Total 2017 Approved Capital		**$200,000**
Total 2017 Remaining		**$133,750**

14. WSIB updates:

Accidents	Incidents	Lost Time	Medical Attention	Outstanding WSIB for Month	Ongoing Outstanding WSIB Claims
0	5	0	0	None at this time	

15. Environmental concerns & emergency preparedness:

Date	Code Practiced	Outcomes/ Barriers
March 18th @ 10:45 am	Code Red	
March 24th@ 3:45 pm	Code Red	
March 17th @ 4:00 am	Code Red	

- New Emergency Manual implemented by March 31, 2017. Education for all staff planned April 3, 4 and 10.