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

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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
Apr 26, 2016	2016_250511_0005	006944-16	Resident Quality Inspection

Licensee/Titulaire de permis

BELLA SENIOR CARE RESIDENCES INC.
1000 FINCH AVENUE WEST SUITE 901 TORONTO ON M3J 2V5

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

BELLA SENIOR CARE RESIDENCES INC.
8720 Willoughby Drive NIAGARA FALLS ON L2G 7X3

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

ROBIN MACKIE (511), IRENE SCHMIDT (510a), KELLY CHUCKRY (611)

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): March 10, 11, 14-18, 21-24 and 29-31, 2016.

During the course of this inspection the following Critical incidents, Complaints and follow up Orders were inspected. 005212-15, 005370-15, 006300-15, 010958, 011754-15, 013535-15, 016868-15, 022978-15, 025641-15, 025644-15, 025963-15, 028661-15, 033226-15, 033694-15, 006207-16 006175-14,

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DOC), Assistant Director of Care (ADOC), Nursing department Assistant Manager, Social Worker, Life Enrichment Coordinator, Nutrition Manager, RAI Coordinator, registered staff including Registered Nurses (RN's) and Registered Practical Nurses (RPN's), Personal Support Workers (PSW's), housekeeping staff, dietary staff, family members and residents. During the course of the inspection the Inspectors observed the provision of resident care, meal service, reviewed applicable policies, practices and resident clinical records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **15 WN(s)**
- **6 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2015_323130_0005	611
O.Reg 79/10 s. 36.	CO #002	2015_323130_0005	611
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2015_323130_0002	611

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 :

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, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

A review of the home's Resident Services Manual included a Pharmacy Services Program which was last reviewed and revised in 2011. The program specified Pharmaceutical services expectations that included the safe, accurate acquisition and dispensing of medications. One area identified was the Medication Reconciliation process. The Medication Reconciliation process was designed to prevent medication errors at patient transition points of care. Medisystem had provided new digital forms to streamline the process. The documented process and form indicated that when obtaining a medication history the nurse was to check all available sources. The documented sources of information were identified on the form as:
1. Resident medication List
2. CCAC
3. Discharge list from hospital/ Specialist
4. Review of Resident Medication Vials
5. Community Pharmacy List
6. MAR from another Facility
7. Patient/Family recall
8. other

The Medication Reconciliation process stated to check as many sources of information as available, to complete the boxes which identified the source of the information and to try to use at least two sources of information to ensure an accurate and complete medication history.

A) A Critical Incident report submitted in September 2014, by the long term care home, identified medication errors that occurred to resident #401. The home identified the error occurred at the time of the resident's admission when their medications were transcribed incorrectly by the admitting RN. The home's practice was for two other nurses to check the order for accuracy and sign the new admission order form in the required section for: Nurse #1 and Nurse #2 signature. The error was not found by the two other nurses who provided the second and third check. A review of the progress notes indicated the resident had a change in their condition. The resident's Substitute Decision Maker (SDM)

came in to see the resident and voiced concerns regarding the resident's sudden declining health to the treating doctor. The doctor assessed the resident and a decision was made to transfer the resident to the hospital. The resident was sent to hospital. A report from the hospital indicated a urine drug screen that was presumptively positive for one of the type of medications, identified by the home as not being transcribed correctly. The treating neurologist report confirmed the resident had inadvertently received an increase in one of their medications and had demonstrated a dramatic decline in cognitive and physical functioning upon admission to the long term care home. The neurologist indicated this was likely partly secondary to the accidental increase in one of the resident's medication dose.

Interview with the RN, who admitted the resident, indicated the resident's SDM had brought the medication bottles to the home on admission. The RN stated they transcribed the medication from the bottles directly onto the new admission order form. Interview with the SDM confirmed they also provided a pharmacy list of medications to the home. A review of the clinical record contained the patient's medical record pharmacy list outlining their list of medications. The pharmacy medication list described the resident's medication and provided different information than what the RN had transcribed on admission from the bottles only. Interview with the RN confirmed they were not aware of a pharmacy list of medications, located in the chart and only used the medication bottles when they transcribed the drugs. Interview with the DOC confirmed resident #401 had been admitted to hospital and was identified as having received the incorrect dose of a medication from their date of admission to the date they were transferred to hospital (14 days). Interview with the DOC and Administrator confirmed the licensee had not followed the home's policy when all three of the registered staff used only one source of information when three sources (Community Pharmacy List, Resident Medication Vials and Patient/Family recall) of information were available to ensure an accurate and complete medication history.

B) The policy, as above, stated that in conjunction with the Medical Directory Committee, a Pharmacy and Therapeutics Committee would be established within the facility. The responsibility of the Pharmacy and Therapeutics Committee was to review all medication error reports and error rates for the purpose of identifying causes and developing policies and procedures to prevent similar occurrences in the future.
Interview with the DOC confirmed the Pharmacy and Therapeutics Committee met quarterly and that the review of medication incidents were limited to include pharmacy errors and the medication incident as described in section A) had not been reviewed with the committee.

Interview with two registered staff had described two conflicting processes for medication reconciliation for resident's on admission or readmission to the home. The DOC further confirmed that the home had not developed a policy nor reviewed the current policy or procedures, taking into consideration any analysis of the medication error, in order to prevent a reocurrence from the date of occurrence in September 2014 to March 2016. [s. 8. (1) (b)]

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,
(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 that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

A) A review of the clinical record for resident #036 revealed they had a wound between

March 2015 and March 2016. Registered nursing staff confirmed weekly skin assessments were to be completed in Point Click Care (PCC) under the assessment tab.

In March 2015 an assessment identified the wound as moderate severity. Subsequent weekly wound assessments were sporadic:
1) April 2015, no wound assessments
2) Two weeks in May 2015 when the wound demonstrated improvement from moderate to mild severity
3) One week in June 2015 scoring the wound as mild severity

No further assessments for the wound were completed until October 2015, a period of more than 4 months, when the wound was determined to be of moderate severity. A culture report was positive for the wound in October 2015 which required treatment. Following this, weekly wound assessments continued to be inconsistently completed:
1) One in November 2016
2) Two in December 2016
3) Three in February 2016
4) One in March 2016
The Assistant Director of Care (ADOC) confirmed resident # 036 experienced altered skin integrity and had not been reassessed at least weekly by a member of the registered nursing staff.

B) A review of the clinical record revealed resident #022 had two wounds between May 2015 and October 2015, a total of 22 weeks.

One of the wounds had been assessed in May 2015 as minimal severity and had only nine weekly assessments completed in 22 weeks. Later, in May 2015, an assessment revealed the wound had an increase to mild severity. Two weekly assessments were completed in each of June and July 2015, and none were completed in August and September 2015.
The second wound was also assessed in May 2015 as mild severity, and had only nine weekly assessments completed in 22 weeks. Two weekly assessments were completed in the months of May, June and July, 2015 and one in August and September, 2015 in spite of the fact that a swab taken during this time was positive for an infection and required treatment.
The above was confirmed by the ADOC. Resident #022 experienced altered skin integrity and was not reassessed at least weekly by a member of the registered nursing staff.

C) Review of the clinical record for resident #016 revealed the presence of two Stage Two pressure ulcers between May 2015 and March 2016.
1) A wound assessment completed in May 2015 identified a new Stage Two pressure ulcer. Weekly wound assessments were completed for this pressure ulcer for one week in June, two weeks in August, 2015 and one week in March 2016. The weekly wound assessment completed March 2016 noted that the skin issue had not resolved. As of the end of March 2016, no further weekly wound assessments had been completed for this wound.
2) A weekly wound assessment in January 2016 identified a new Stage Two pressure ulcer. Weekly wound assessments were completed for this wound every two weeks - with resolution identified in March 2016.

Clinical records were reviewed with the ADOC who confirmed that resident #016 exhibited altered skin integrity, specifically two pressure ulcers, between May 2015 and March 2016 and they were not reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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. (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).

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 resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A)
i. In 2015, an incident of responsive behaviour occurred between resident #500 and resident #507. During this incident, resident #500 grabbed resident #507. In this specific instance, the SDM of resident #507 was not notified, therefore was not given the opportunity to participate fully in the plan of care.

ii. In 2015, an incident of responsive behaviour occurred between resident #500 and resident #513. During this incident, resident #500 physically struck resident #513. In this specific instance, the SDM of resident #513 was not notified, therefore was not given the opportunity to participate fully in the plan of care.

An interview with the Associate Director of Resident Care (ADOC) confirmed the SDM's were not notified of the incidences towards resident #507, and #513. (611)

B) Resident #401 was admitted to the home in 2014 with a multitude of diagnoses that would determine their care needs. A review of the clinical record indicated the resident had cognitive impairment and had been described as moderately impaired with poor decision making. The resident's substitute decision maker (SDM) had visited often and was noted to be very involved in the resident's care decisions.
The resident was sent to hospital in 2014 for a deterioration in their condition. They returned to the home with a new medication that was to be given every four hours as needed. The readmission reconciliation order form indicated it was a continued medication from the hospital and the home's medication form did not indicate the SDM was informed of the medication. On further review and interview with the Director Of Nursing (DOC) it was confirmed the original medication order came from the hospital on discharge. A different family member became concerned and notified the SDM when the medication was administered to the resident at the long term care home. Interview with the SDM indicated they were concerned that the resident received a new medication that they were not informed of and were not consulted with prior to the administration of this medication. A review of the clinical record did not indicate the SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care when a new medication was administered to the resident at the long term care home. (511) [s. 6. (5)]

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.

A) Resident #400 was admitted to the home in 2014 and was assessed as a high risk for falls on the Falls Risk Assessment Tool (FRAT). The resident sustained a fall in 2014 which resulted in treatment for an injury. The resident fell again in 2014 and had no further falls until 2015. The resident's plan of care indicated the resident wore a physical restraint which consisted of a seat belt while up in their wheelchair for safety. In 2015, the resident was documented to have fallen from their wheelchair and sustained an injury that required hospitalization. A progress note at the time of the fall, by the RPN on duty, indicated that on investigation it was determined that the PSW staff had not fastened the seat belt when resident #400 had been transferred from bed to wheelchair prior to dinner. Interview with the DOC confirmed the care set out in the plan of care was not provided to the resident as specified in the plan when their seat belt was not secured.

B) Resident #035 was admitted in 2013 with medical conditions that may have put them at risk for falls. Their last annual assessment indicated they had moderate cognitive impairment and there was also a language barrier. They knew enough English and with

gestures could make known their care requirements. A review of their clinical record indicated they started to complain of pain to an area on their body on a specific day in 2016. The Substitute Decision Maker (SDM) requested an a diagnostic test for the resident 4 days later. Interview with the SDM indicated it was difficult and appeared to take a long time to obtain a follow-up on the diagnostic test and treatment when the resident had experienced pain. A physician order was documented eight days after the onset of pain in 2016 for a diagnostic test to the affected area. The order was processed and checked by another registered staff on the day of the doctors order and the box that indicated the lab/x-ray was notified, was checked off as being notified. Two weeks after the order was transcribed a diagnostic test was completed. Interview with registered staff #110 confirmed the home's process would have been to fax a referral to the diagnostic imaging company the same day or the next but not two weeks later. A review of the confirmation fax sheet indicated the fax request for the diagnostic test was sent two weeks later and not on the day when the order was processed.
The Doctor reviewed the test results, which were negative for an injury, to the affected area and requested the Physiotherapist (PT) to assess. A referral was sent to the PT the following day. A review of the Point Click Care (PCC), which was the home's electronic documentation system, indicated that the PT had seen the resident two weeks later and the Physiotherapist had requested the registered staff to follow up with a request for another diagnostic test. The resident continued to experience pain to their affected area during that time. Interview with the PT confirmed they had initially seen the resident only a few days after the doctor had made the request for follow-up, not two weeks as indicated in PCC, and had spoken to the registered staff and requested further tests at that time. The PT stated when they saw the resident again the following week the test had still not been ordered as set out in the plan of care, and that they had spoken again to another registered staff who then obtained the order and documented in PCC. The PT stated they had not transferred their hand written notes/assessment over to the PCC system. Interview with the registered staff confirmed they would not read the written assessment notes by the PT but would review the PCC assessment notes. The second test, of another area close in proximity to the affected area, was completed and results showed an injury and an increase to the resident's pain medication was provided for pain control. Interview with staff member #110 and #111 confirmed the doctor's order for a diagnostic test were not completed when ordered and the request for a follow-up test had not been completed when requested by the PT. Interview with the DOC confirmed the physician's orders and the paper copies of the physiotherapy assessment form were part of the resident's plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of

care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs changed or care set out in the plan was no longer necessary.

A) During the Resident Quality Inspection (RQI), Resident #041's continence Quality of Life Indicator (QCLI) from Stage One triggered for the period of August 2015 through February 2016. A review of the MDS assessment for their bowel continence for August 2015 indicated the resident had been continent of their bowels. Six months later, on the February 2016 MDS assessment, it indicated that resident #041 was now frequently incontinent of their bowels, two to three times a week during the review period. A review of the Resident Assessment Protocol (RAP) for the same period did not indicate the resident had been reassessed and the plan of care reviewed when the resident's care needs changed. Interview with registered staff #102 confirmed resident #041's care needs changed when they changed from being continent of their bowels to frequently incontinent and that the resident had not been reassessed nor the plan of care reviewed and revised for these changes.

B) During the Resident Quality Inspection (RQI), Resident #022's continence Quality of Life Indicator (QCLI) from Stage One triggered for the period of August 2015 through February 2016. A review of the MDS assessment for their bowel continence for August 2015 indicated the resident had been usually continent of their bowels. Six months later, on the February 2016 MDS assessment, it indicated that resident #022 was now frequently incontinent of their bowel, two to three times a week during the review period. A review of the Resident Assessment Protocol (RAP) for the same period did not indicate the resident had been reassessed and the plan of care reviewed when the resident's care needs changed. Interview with registered staff #102 confirmed resident #022's care needs changed when they went from being continent of their bowels to frequently incontinent and that the resident had not been reassessed nor the plan of care reviewed and revised for these changes.

C) Resident #045 was admitted in 2015. The resident experienced a change in their medical condition which resulted in surgery one month after their admission. The resident further developed complications and their condition deteriorated to where they required palliative care. The resident deceased the following month. A review of the resident plan of care, at the time of death, did not indicate the resident's significant change in condition and had not identified care needs for comfort and palliation. Interview with the ADOC confirmed resident #045's plan of care was not reviewed and revised when, (b) the resident's care needs changed or care set out in the plan was no longer necessary.

D) Resident #035 had complained of pain to an area of their body in 2016. This continued and the resident had a diagnostic test of their affected area which indicated there was no injury. The resident's medications were changed to include a new medication for pain control. The Physiotherapist recommended transferring, positioning and posture supports to manage pain and had advised the use of a supportive brace.

A review of the most recent plan of care, with the ADOC, confirmed the plan of care had not been revised and updated with the resident's most recent change in condition as a result of their diagnosed injury. [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 to ensure the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: 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 there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

A) As part of the home's Abuse and Neglect Prevention Program, the home had a policy entitled "Abuse and Neglect Prevention". This policy's statement of purpose indicated the home supported a zero tolerance policy as it related to abuse/neglect. The definition

of emotional abuse as indicated in this policy was any threatening, insulting, intimidating, or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgment or infantilization that were performed by anyone other than a resident. It also included any threatening or intimidating gestures, actions, behaviour or remarks by a resident that caused alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understood and appreciated their consequences.

Resident #517 had a medical condition that had included cognitive impairment. Their Outcome Summary Report, specific for a month in 2016, confirmed the resident had a Cognitive Performance Score of five (5), which indicated severe cognitive impairment.

For three months in 2015, the home had an open period with respect to their collective agreement. It had been reported that there was a dispute between the Healthcare Office and Professional Employees Union (HOPE) and Unifor.

On a day in 2016, resident #517 was chanting a specific phrase. Staff #107 and #108 encouraged the resident to chant "Don't be a dope, vote for Hope". Staff #106 approached the resident during the chanting and encouraged the resident to chant "Sweep the floor with Unifor". During this incident, all three staff identified above were laughing at the resident as these chants were recited.
Staff #108 audio taped the resident making these chants on a personal cell phone. This audio tape was shown to staff members in the building on a specific evening in 2016.

Upon reflection of the incident that occurred on a specific day in 2016, staff #106 and #107 recognized the incident as emotional abuse towards resident #517, as the actions infantilized and humiliated resident #517.

During an interview with the Director of Resident Care, it was confirmed that the actions of the staff members involved with this incident were abusive in nature and the staff involved were disciplined.

B) The home has a current policy entitled "Abuse and Neglect Prevention". This policy was part of the home's abuse and neglect prevention program. The policy stated that "the Administrator/Designate shall notify the Ministry of Health and Long Term Care immediately via Critical Incident Reporting System or via pager (after hours or holidays)".

On a day in 2016, an incident of abuse/neglect occurred towards resident #517. This incident was not reported to The Ministry of Health and Long Term Care until twelve (12) days after the incident. The Critical Incident Report submitted contained a note that indicated the submission was completed late due to the lengthy investigation to review all the facts.

An interview with the Director of Care (DOC) confirmed that the home did not follow their policy on Abuse and Neglect Prevention, and further confirmed the submission to the Ministry of Health was not immediately submitted.

C) The home's policy on "Abuse and Neglect Prevention" further stated that the Administrator/Designate shall notify the POA/SDM within 12 hours of becoming aware of any alleged, suspected, or witnessed incident of abuse or neglect of a resident. An incident of abuse occurred towards resident #517 on a specific day in 2016. Resident #517's SDM was not notified of the incident until 11 days after the incident.
An interview with the Director of Resident Care confirmed this notification of the SDM was not conducted immediately, and the home's policy on "Abuse and Neglect Prevention" was not complied with. [s. 20. (1)]

Additional Required Actions:

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

WN #5: 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 :

1. The licensee has failed to ensure that the following interdisciplinary program was implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

A) A review of the licensee's 3.6 Falls Prevention Program (revised last on April 2013) and reviewed by the home on June 2015 indicated the DOC and the Quality Management team would review all falls in the facility on a quarterly basis to monitor and track falls for developing trends. The falls committee was to examine falls and the DOC or Quality management team was required to look for systemic issues such as staffing when falls occurred, environmental issues and resident frequency of falls. A report was to be prepared quarterly for the Quality management team and presented to the DOC. A review of the clinical record indicated resident #400 and resident #501 had experienced a fall that resulted in an injury in 2015. Interview with the DOC confirmed the Quality Management team had not reviewed the falls in the facility on a quarterly basis or monitored and tracked the falls for a development in trends as per the above Falls Prevention Program.

B) A review of the clinical record indicated resident #402 had experienced multiple falls in 2015 and a few falls in 2016. Interview with the DOC confirmed the Quality Management team had not reviewed resident #402's falls on a quarterly basis or monitored and tracked the falls for a development in trends as per the above Falls prevention Program.

C) A review of the licensee's ~~3.6~~ Falls Prevention Program (revised last on April 2013) and reviewed by the home last on June 2015 indicated the purpose of the program was to monitor and evaluate resident outcomes for falls. The Falls prevention program identified that an 'at risk' indicator would be placed on the chart, outside the room and at the bedside. Observation of resident #402's chart, outside the room and at the bedside did not indicate an 'at risk" logo. Interview with the RPN on the unit confirmed resident #402 was at a high risk for falls and that the home used a falling star logo as a high risk indicator and this logo was not in place for this resident.

D) A review of the licensee's 3.6 Falls Prevention Program (revised last on April 2013) and reviewed by the home last on June 2015 indicated the resident would be assessed and reassessed every 8 hours for the next 72 hours and included a pain assessment and a head injury routine when there was suspicion of a head injury.
A review of the clinical record for resident #402 indicated the resident was a high risk for falls and sustained several falls in 2015. One of the falls was described as an un-witnessed fall and they sustained a laceration, swelling and subsequent bruising to their head and face region. During the following 72 hours after the fall there was one pain assessment completed and the documentation indicated their facial expression reflected possible pain. Interview with RPN #114 stated a Neurological assessment record was what the home used for a head injury routine (on un-witnessed falls) and documentation of assessment for the resident would include monitoring neurovital signs 30 minutes x 1hour, every hour x 2 hours, every 4 hours x 24 hours and every 8 hours x 72 hours. Interview with RPN #114 confirmed their was no evidence that the neurological assessments or pain assessments form was completed as per the home's policy. Interview with the ADOC confirmed the falls management program had not been implemented for resident #402 when they experienced an un-witnessed fall with injury [s. 48. (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 that the following interdisciplinary program is implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home submitted a Critical Incident report (CIS) in 2015 that indicated resident #501 had a fall on two separate days in 2015. On one of the days the resident's fall resulted in a transfer to hospital where they were treated for an injury. A review of their clinical record did not indicate a post falls assessment was completed for either of the two falls. A review of the home's Falls prevention program indicated the home used a Post Fall Incident Investigation Tool as their clinically appropriate assessment instrument that was specifically designed for falls. Interview with the DOC confirmed the licensee failed to ensure that when resident #501 had fallen, the resident had a post-fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 they responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

At the June 23, 2015 Residents' Council meeting, a concern was identified. The concern indicated that the dining rooms were too cold during the meal service and staff were having to get sweaters for residents during the meal service. It was further described, in the minutes, as making the dining uncomfortable for residents. Another concern identified during the same meeting, that the deserts were being placed on the tables too early, and was a concern especially when the desert was ice cream. The minutes requested a resolution to the issue as it had become an ongoing problem.

At the July 23, 2015 Residents' Council meeting two concerns were identified as reflected in the minutes. The first concern was that the flowers from the resident family room were missing. A request was made to have these flowers replaced.
The second concern as identified in the minutes indicated that a resident rang the bell for help and waited over twenty (20) minutes to have the call bell answered. The minutes

indicated a PSW told the resident they were on a break.

At the August 25, 2015 Residents' Council meeting, a concern was identified as it related to the meal service. The minutes indicated a concern that the spinach and poached eggs were too watery when served. A request was made to have these items served in a bowl. The minutes further indicated a concern that the home ran out of food, specifically for seven (7) residents, when there was no spaghetti and the residents had to wait twenty (20) minutes for their dinner.

Upon further review of the subsequent Residents' Council minutes, a written response was not provided to the above noted concerns from Residents' Council. A response was required in writing within ten (10) days of receiving any concerns from Residents' Council.

At the September 22, 2015 Residents' Council meeting, a concern was identified as to whether staff from the laundry department were able to start delivering clothing to residents, instead of the Personal Support Workers (PSW's). The concern identified that too many mistakes were being made and the PSW's were rushed.

A subsequent meeting took place on October 27, 2015, and it was identified that the home had looked into the possibility of staff from the laundry department being able to deliver clothing to the residents. On November 24, 2015 a response was provided in the minutes of that meeting, indicating that the delivery of laundry was a PSW role, as it was in their job description to deliver laundry.
This response was not completed within ten (10) days of receiving the concern from Residents' Council.

An interview with staff #111 and the Director of Resident Care confirmed that the home had not provided responses in writing within ten (10) days of receiving concerns from Residents' Council. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1) the licensees shall, within 10 days of receiving the advice, respond to the Residents' Council in writing, to be implemented voluntarily.

WN #8: 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:

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 they sought the advice of the Residents' Council when developing and carrying out the satisfaction survey, and in acting on its results.

The home failed to circulate the 2015 Resident Satisfaction Survey to all residents in the home. A total of five (5) Resident Satisfaction Surveys were completed when staff #112, personally handed the surveys to only those five (5) residents. In addition, the home failed to seek advice from the council in the development of the questions contained in the satisfaction survey. This was further confirmed by review of the 2015 Residents' Council minutes.

An interview with staff #111 and the Director of Care confirmed that the home did not circulate the 2015 Resident Satisfaction Survey to all residents and did not seek the advice of Resident's Council in the development of the questions contained in the residents satisfaction survey. [s. 85. (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 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, to be implemented voluntarily.

WN #9: 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:
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 following rights of residents were fully respected and promoted: 11. Every resident had the right to, 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.

An initial tour was conducted in the home on March 10, 2016. During this tour, the Inspector reviewed all copies of the inspection reports that were in a binder on a communication board in the home. This review revealed a licensee copy of inspection #2015_323130_0002 for an RQI inspection. This licensee report contained confidential personal information of several residents as it related to that RQI inspection. This licensee copy of the report was removed and to be replaced with the public copy of this report.

An interview with the Administrator and Associate Director of Resident Care (ADOC) confirmed the licensee copy of the report was incorrectly posted, revealing confidential personal information. [s. 3. (1) 11. iv.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) Resident #006 was admitted to the home in 2015. The care plan for this resident indicated that both the right and left bed rails were to be raised to enable the resident to grasp bed rails for assistance with turning in bed. Upon further review of the resident's clinical record, the resident was not assessed for the use of these bed rails to minimize the risk to the resident.

An interview with staff #012 and staff #001 confirmed that resident #006 was not assessed for the use of bed rails to minimize the risk to the resident. This was further confirmed by an interview with the Assistant Director of Resident Care. (611)

B) On two separate dates, during the Resident Quality Inspection in 2016, the unoccupied bed of resident #015 was observed to have one bed rail in the assist position and one bed rail in the guard position. The document the home referred to as the care plan directed that resident #015 used both rails in the guard position while in bed during the night for comfort and repositioning. The clinical record did not include an assessment of the resident that would minimize the risk to the resident. Registered staff #013 and the ADOC confirmed the resident had not been assessed for use of bed rails in accordance with evidence based practices. (510a)

C) On two separate dates, during the Resident Quality Inspection in 2016, resident # 026 was observed in bed with two, three quarter side rails raised. This direction was found in the document the home referred to as the care plan. The clinical record did not include an assessment of the resident in accordance with evidence based practices. Registered staff #031 and the ADOC confirmed the resident had not been assessed for use of bed rails in accordance with evidence based practices. (510a) [s. 15. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that, (b) 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) A review of resident #041's most recent Minimum Data Set (MDS) quarterly assessment, dated for a month in 2016, indicated they were frequently incontinent of their bowels, two to three times a week. Their plan of care stated they were to wear a medium brief at all times and they were on a toileting schedule that required two person extensive assistance with a sit to stand transfer aid to be provided at 0730, 0930, 1130, 1330, 1530, 1730 and 1930 hours. Observation and interview with the resident indicated they were not toileted as per the written plan of care and were wearing a large/extra large brief. There had been a large/extra large brief stored in the resident's bathroom and the resident stated the staff put whatever brief they had available on them. The resident indicated they self transferred on the toilet, when needed, not every two hours by staff, and rang the bell for assistance to transfer off the toilet. Interview with PSW #101 confirmed the resident was not toileted every two hours as per the plan of care and had not been assisted into the correct continence product as specified in the plan of care.

B) A review of resident #042's most recent MDS quarterly assessment, dated for a month in 2016, indicated they were frequently incontinent of their bladder and tended to be incontinent daily, but had some control present. Their plan of care stated they were to wear a medium brief at all times and they were on a toileting schedule for 0800, 1000, 1300, 1500, 1700 and 1900. On observation it was observed they were not toileted as per the written plan of care. Interview with PSW #103 indicated the resident often self transferred themselves on the toilet when needed and then rang the bell for assistance to transfer off the toilet. PSW #042 confirmed the resident had not been toileted as described in the most recent plan of care. [s. 51. (2) (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) On a day in 2015, an incident of responsive behaviour occurred between resident #500 and resident #507. During this incident, resident #500 grabbed resident #507. Resident #507 was not assessed after this incident, and the home failed to document this incident in the progress notes for resident #507.

B) On a day in 2015, an incident of responsive behaviour occurred between resident #500 and resident #511. During this incident, resident #500 physically struck resident #511. Resident #511 was not assessed after this incident and the home failed to document this incident in the progress notes for resident #511.

C) On a day in 2015, an incident of responsive behaviour occurred between resident #500 and resident #513. During this incident, resident #500 physically struck resident #513. Resident #513 was not assessed after this incident and the home failed to document this incident in the progress notes for resident #513.

An interview with the Associate Director of Resident Care (ADOC) confirmed that assessments were not completed for resident #507, #511 and #513. [s. 53. (4) (c)]

WN #13: 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. The licensee has failed to ensure that the required information was posted for the purposes of subsections (1) and (2) was, (k) copies of the inspection reports from the past two years for the long-term care home.

On the initial tour of the home, that was conducted on March 10, 2016, it was noted that the home did not have copies of all inspection reports posted for the past two years. Specifically, a total of five (5) inspection reports were not posted, with the following inspection numbers:
-2015_323130_0015
-2015_189120_0045
-2015_189120_0046
-2015_342611_0002
-2014_191107_0016

An interview with the Administrator and Associate Director of Resident Care confirmed that the required information, as it related to posting of inspection reports, was not posted by the home. [s. 79. (3) (k)]

WN #14: 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).

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 was 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).

A written complaint, dated in September 2015, was forwarded to the home with an attention to the DOC and Administrator. A copy of this letter was found in the home's complaint log with an associated suggestion, concern and complaint form. The form was incomplete. Specifically, it did not contain information regarding:
1) final resolution
2) date(s)on which any response was provided to the complainant and a description of the response

3) any response made by the complainant

The DOC confirmed that the home's policy required a written response to the complainant within ten days of receipt of the complaint and that such a response had not been provided to the complainant. [s. 101. (1) 3.]

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

On a day in February, 2016 it was reported that resident #518 was missing a personal belonging. This was documented in the clinical record of resident #518, however the home failed to document this information in the 2016 complaint log.

According to the home's policy on "Concerns, Issues and Complaints", a suggestions, concerns and complaint form was to be completed and added to the home's complaint log. This form was not completed for this resident's missing personal belonging.

An interview conducted with the Director of Care (DOC) confirmed that this information was not documented in the home's complaint log. [s. 101. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training shall be provided to all staff who provided direct care to residents: 1. Falls prevention and management.

Resident #402 was identified as a high risk for falls and sustained a fall in 2016. The RPN, that provided care to the resident on the day of the fall, had not completed a pain assessment, a neurological assessment record for the un-witnessed fall, nor started the falls incident checklist, which was to be completed after each fall on individual residents. The RPN's date of hire was February 6, 2016. Interview with RPN #114 confirmed they provided mentoring on three days but that a fall had not occurred during that time and they did not remember if they reviewed the falls program process with the new RPN during these three days. Interview with the staff educator confirmed a one page overview entitled "Fall Protocol", was provided to the new RPN but this document did not encompass all the education required for the home's Falls Prevention and Management program. The ADOC confirmed the new RPN had worked 75.65 hours (9 shifts) and provided direct care to residents without being provided training on the home's Fall's prevention and management program. [s. 221. (1) 1.]

Issued on this 13th 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

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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROBIN MACKIE (511), IRENE SCHMIDT (510a), KELLY CHUCKRY (611)
Inspection No. / No de l'inspection :	2016_250511_0005
Log No. / Registre no:	006944-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 26, 2016
Licensee / Titulaire de permis :	BELLA SENIOR CARE RESIDENCES INC. 1000 FINCH AVENUE WEST, SUITE 901, TORONTO, ON, M3J-2V5
LTC Home / Foyer de SLD :	BELLA SENIOR CARE RESIDENCES INC. 8720 Willoughby Drive, NIAGARA FALLS, ON, L2G-7X3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dale Cowan

To BELLA SENIOR CARE RESIDENCES 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. 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 :

The Licensee shall do the following for achieving compliance with LTCHA, 2007 S.O. 2007, Ontario Regulation 79/10 r.8, (1) (b).
(a) Undertake an analysis and evaluation of the medication reconciliation process at patient transition points of care in conjunction with the medication error made on September 11, 2014 to resident #401 and identify changes and improvements required to prevent further incidents of transcription errors; and
(b) Develop and implement comprehensive policies and procedures, if necessary, to address medications reconciliation and transcription errors taking into consideration the changes and improvements identified through the evaluation outlined in (a) above.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (4), in keeping with s.299(1) of the Regulation, in respect of the actual harm that resident #401 experienced, the scope of isolated, and the Licensee's history of non-compliance (VPC) on the February 3, 2015 Resident Quality Inspection with r.8 (1) (b) related to following the home's medication policy.

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was

required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

A review of the home's Resident Services Manual included a Pharmacy Services Program which was last reviewed and revised in 2011. The program specified Pharmaceutical services expectations that included the safe, accurate acquisition and dispensing of medications. One area identified was the Medication Reconciliation process. The Medication Reconciliation process was designed to prevent medication errors at patient transition points of care. Medisystem had provided new digital forms to streamline the process. The documented process and form indicated that when obtaining a medication history the nurse was to check all available sources. The documented sources of information were identified on the form as:
1. Resident medication List
2. CCAC
3. Discharge list from hospital/ Specialist
4. Review of Resident Medication Vials
5. Community Pharmacy List
6. MAR from another Facility
7. Patient/Family recall
8. other

The Medication Reconciliation process stated to check as many sources of information as available, to complete the boxes which identified the source of the information and to try to use at least two sources of information to ensure an accurate and complete medication history.

A) A Critical Incident report submitted in September 2014 by the long term care home identified medication errors that occurred to resident #401. The home identified the error occurred at the time of the resident's admission when their medications were transcribed incorrectly by the admitting RN. The home's practice was for two other nurses to check the order for accuracy and sign the new admission order form in the required section for: Nurse #1 and Nurse #2 signature. The error was not found by the two other nurses who provided the second and third check. A review of the progress notes indicated the resident had a change in their condition. The resident's Substitute Decision Maker (SDM) came in to see the resident and voiced concerns regarding the resident's sudden declining health to the treating doctor. The doctor assessed the resident and a decision was made to transfer the resident to the hospital. The resident

was sent to hospital. A report from the hospital indicated a urine drug screen that was presumptively positive for one of the type of medications, identified by the home, as not being transcribed correctly. The treating neurologist report confirmed the resident had inadvertently received an increase in one of their medications and had demonstrated a dramatic decline in cognitive and physical functioning upon admission to the long term care home. The neurologist indicated this was likely partly secondary to the accidental increase in one of the resident's medication dose.

Interview with the RN who admitted the resident indicated the resident's SDM had brought the medication bottles to the home on admission. The RN stated they transcribed the medication from the bottles directly onto the new admission order form. Interview with the SDM confirmed they also provided a pharmacy list of medications to the home. A review of the clinical record contained the patient's medical record pharmacy list outlining their list of medications. The pharmacy medication list described the resident's medication differently than the RN had transcribed on the admission order form. Interview with the RN confirmed they were not aware of a pharmacy list of medications, located in the chart and only used the medication bottles when they transcribed the drugs. Interview with the DOC confirmed resident #401 had been admitted to hospital and was identified as having received the incorrect dose of a medication from their date of admission to the date they were transferred to hospital (14 days). Interview with the DOC and Administrator confirmed the licensee had not followed the home's policy when all three of the registered staff used only one source of information when three sources (Community Pharmacy List, Resident Medication Vials and Patient/Family recall) of information were available to ensure an accurate and complete medication history.

B) The policy, as above, stated that in conjunction with the Medical Directory Committee, a Pharmacy and Therapeutics Committee would be established within the facility. The responsibility of the Pharmacy and Therapeutics Committee was to review all medication error reports and error rates for the purpose of identifying causes and developing policies and procedures to prevent similar occurrences in the future.
Interview with the DOC confirmed the Pharmacy and Therapeutics Committee met quarterly and that the review of medication incidents were limited to include pharmacy errors and the medication incident as described in section A) had not been reviewed with the committee. Interview with two registered staff had

described two conflicting processes for medication reconciliation for resident's on admission or readmission to the home. The DOC further confirmed that the home had not developed a policy nor reviewed the current policy or procedures, taking into consideration any analysis of the medication error, in order to prevent a reoccurrence from the date of incident in September 2014 to March 2016. (511)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 16, 2016

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. 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 ensure that a resident that exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, will be reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. This Order shall include resident #036, #022 and #016 where appropriate.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident that exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) A review of the clinical record for resident #036 revealed they had a wound between March 2015 and March 2016. Registered nursing staff confirmed weekly skin assessments were to be completed in Point Click Care (PCC), under the assessment tab.
In March 2015 an assessment identified the wound as moderate severity.
Subsequent weekly wound assessments were sporadic:
1) April 2015, no wound assessments
2) Two weeks in May 2015 when the wound demonstrated improvement from moderate to mild severity
3) One week in June 2015 scoring the wound as mild severity

No further assessments for the wound were completed until October 2015, a period of more than four months, when the wound was determined to be of moderate severity. A culture report was positive for the wound in October 2015 which required treatment. Weekly wound assessments continued to be inconsistently completed:
1) One in November 2016
2) Two in December 2016
3) Three in February 2016
4) One in March 2016
The Assistant Director of Care (ADOC) confirmed resident # 036 experienced altered skin integrity and had not been reassessed at least weekly by a member of the registered nursing staff.

B) A review of the clinical record revealed resident #022 had two wounds between May 2015 and October 2015, a total of 22 weeks.

One of the wounds had been assessed on a date on May, 2015 as minimal severity and had only nine weekly assessments completed in 22 weeks. Later in May, 2015 an assessment revealed the wound had an increase to mild severity. Two weekly assessments were completed in each of June and July 2015, and none were completed in August and September 2015.
The second wound was also assessed in May 2015 as mild severity, and had only nine weekly assessments completed in 22 weeks. Two weekly assessments were completed in the months of May, June and July 2015 and one in August and September 2015 in spite of the fact that a swab taken during this time was positive for an infection and required treatment.
The above was confirmed by the ADOC. Resident #022 experienced altered skin integrity and was not reassessed at least weekly by a member of the registered nursing staff.

C) Review of the clinical record for resident #016 revealed the presence of two Stage Two pressure ulcers between May 2015 and March 2016.
1) A wound assessment completed in May 2015 identified a new Stage Two pressure ulcer. Weekly wound assessments were completed for this pressure ulcer for one week in June, two weeks in August 2015 and one week in March 2016. The weekly wound assessment completed March 2016 noted that the skin issue had not resolved. As of the end of March 2016, no further weekly wound assessments had been completed for this wound.
2) A weekly wound assessment in January 2016 identified a new Stage Two pressure ulcer. Weekly wound assessments were completed for this wound every two weeks - with resolution identified in March 2016.

Clinical records were reviewed with the ADOC who confirmed that resident #016 exhibited altered skin integrity, specifically two pressure ulcers, between May 2015 and March 2016 and they were not reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)] (510a)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 16, 2016

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
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 sions 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 sions 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 26th day of April, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Robin Mackie

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