Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 8, 2019	2019_703625_0002	027244-18, 027245-18	Follow up

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street P.O. Box3251 THUNDER BAY ON P7B 5G7

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

Bethammi Nursing Home
63 Carrie Street THUNDER BAY ON P7A 4J2

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

KATHERINE BARCA (625), SHARON GOERTZEN (742)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 8 to 11, 14 to 18 and 22 to 25, 2019.

The following intakes were completed during this inspection:
- one log related to CO #002 from inspection #2018_616542_0015, issued pursuant to the Long-Term Care Homes Act (LTCHA), 2007, s. 6 (1) (c); and
- one log related to CO #001 from inspection #2018_616542_0015, issued pursuant to the LTCHA, 2007, s. 6 (9) 1.

Complaint inspection #2019_703625_0001 and Critical Incident System (CIS)

inspection #2019_703625_0003 were conducted concurrently with this Follow-up inspection.

Findings of non-compliance pursuant to the LTCHA, 2007, s. 6 (1) (c) and Ontario Regulation (O. Reg.) 79/10, s. 131 (2) identified during the CIS inspection have been issued in this Follow-Up inspection report.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), the RAI Coordinator/Scheduling Clerk, PSWs from the Behavioural Supports Ontario Mobile Outreach Team, a Maintenance employee, the Environmental Services Supervisor, a Registered Dietitian (RD), Directors of Care (DOCs) and the Administrator.

The Inspectors also conducted observations of the care and services provided to residents, of resident to resident interactions, of staff to resident interactions, and of behaviours exhibited by residents. The Inspectors reviewed records including resident health care records (MED e-care progress notes, electronic Medication Administration Records (eMARs), electronic Treatment Administration Records (eTARs), care plans, Kardexes, quarterly Physician Reviews, Order Sheets and Progress Note documents, etc.), email communication, home's investigation files, Narcotic/Controlled Drug Records, Narcotic/Controlled Drug Inventory Records, medication related safety reports, a Pharmacy Dispensing Error Report, topical drug audits, Dietary Reports, Flow Sheet reports, RPN 24 Hour Reports, portions of employee personnel files pertaining to staff qualifications, staff schedules and relevant licensee, home and pharmacy policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 VPC(s)
2 CO(s)
1 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

Compliance Order (CO) #002 was issued from inspection #2018_616542_0015 pursuant to the Long-Term Care Homes Act (LTCHA), 2007, s. 6 (1) (c). The order required the licensee to be compliant with s. 6 (1) (c) of the LTCHA. The compliance due date was October 26, 2018.

Inspector #625 reviewed documents pertaining to CO #002 provided by the home including a document titled Bethammi High Choke Risk List January 2019. The list identified residents #006 and #007 had been assessed as being at risk to choke.

(a) The Inspector reviewed resident #006's current care plan and Kardex. Both documents identified the resident as a choke risk and listed the resident's diet texture as two different textures.

During an interview with RD #103, they reviewed resident #006's care plan and Kardex and acknowledged that the plan of care was unclear regarding the resident's diet texture.

During an interview with the Administrator, they reviewed resident #006's current care plan and Kardex and acknowledged that the resident's plan of care did not provide clear

direction with respect to the resident's diet texture.

(b) The Inspector also reviewed resident #007's current care plan and Kardex. Both documents identified the resident as being at risk to choke and identified the resident:
- required two different diet textures;
- required fluids of two different consistencies;
- required two different minimum fluid requirements per day; and
- staff were to encourage the resident to drink fluids, and listed specific beverages the resident liked to drink. However, elsewhere the documents indicated that staff were to limit one of the specific beverages liked by the resident.

Resident #007's current care plan also identified expected outcomes for resident #007 as both maintaining their current body weight/changing their weight towards a body weight within one range in the next three months, and as consuming adequate nutrition to maintain their weight within a different range.

The care plan identified the resident's body mass index (BMI) as two different values; while the Kardex listed the resident's BMI as a third value.

During an interview with RD #103, they reviewed the care plan and Kardex for resident #007 and acknowledged that the plan of care was unclear regarding the resident's required diet texture, fluid consistency, minimum daily fluid requirement, ingestion of a particular beverage, weight goals and BMI.

During an interview with the Administrator, they reviewed resident #007's current care plan and Kardex and acknowledged that the resident's plan of care did not provide clear direction with respect to the resident's required diet texture, fluid consistency, minimum daily fluid requirement, ingestion of juices, weight goals and BMI. [s. 6. (1) (c)]

2. CO #001 was issued from inspection #2018_616542_0015. During inspection of CO #001, Inspector #625 identified non-compliance pursuant to the LTCHA, 2007, s. 6 (1)(c).

(a) During a review of eTARs/eMARs for resident #028 from November 16, 2018, to January 10, 2019, Inspector #625 noted an entry for a treatment to the resident.

During interviews with resident #028, they stated that they used the treatment.

During an interview with PSW #104, they stated that they had known and provided care

to resident #028 for a period of time, and the resident used the treatment.

During an interview with RPN #106, they stated they were familiar with resident #028 but did not believe the resident had the treatment as they had never signed for it on the eMAR/eTAR.

During an interview with RAI Coordinator #105, they contacted the pharmacy provider about resident #028's treatment. The RAI Coordinator stated the pharmacy had informed the RAI Coordinator that the order had been incorrectly entered as an eMAR note and not as a treatment order and, as a result, registered staff had not been able to view the treatment as an order to be completed.

(b) During a review of eTARs/eMARs for resident #028 from November 16, 2018, to January 10, 2019, Inspector #625 noted an entry for a treatment for multiple dates. The entry did not reflect that the treatment had been provided to the resident.

During an interview with RN #107, they stated that resident #028’s treatment had been entered onto the eTAR by the pharmacy provider, after the home had been relying exclusively on the eMAR, which resulted in the order on the eTAR being unseen by registered nursing staff.

During an interview with the DOC, they reviewed the eMAR/eTAR and acknowledged that all treatments of a specific characteristic should have been moved from the eTAR to the eMAR, as the home no longer referred to the eTAR for treatments.

In summary, the licensee failed to ensure that the plan of care provided clear directions to staff with respect to resident #028’s use of one treatment that was not listed on the eMAR/eTAR in the manner required for staff to be aware of and document its use; and a second treatment, which had been entered by the pharmacy on the eTAR, after the home had transitioned to using the eMAR as the exclusive document for all treatments. [s. 6. (1) (c)]

3. CO #001 was issued from inspection #2018_616542_0015. During inspection of CO #001, Inspector #625 identified non-compliance pursuant to the LTCHA, 2007, s. 6 (1)(c).

(a) Inspector #625 reviewed the eTAR/eMAR for resident #027 from November 16, 2018, to January 9, 2019, and noted multiple entries for the same treatment. One entry identified the treatment was to be done at a specific frequency, while the another entry

listed the treatment was to be done at a different frequency.

The Inspector reviewed a Physician Review from the winter of 2018, which indicated the treatment was to be done at a specific frequency. The treatment orders did not identify the treatment was to be done at the other frequency listed in the eMAR/eTAR.

During an interview with PSW #108, they stated they knew that a specific treatment was ordered if the RPN told them to complete the treatment. The PSW stated they had completed the treatment to resident #027 at a frequency that differed from the previous two frequencies listed on the eMAR/eTAR, but had not been aware that it was a Physician's order. The PSW reviewed the eMAR entries for the treatment and acknowledged the entries were not clear as to whether the treatment was to be completed at one frequency, or at another frequency.

During an interview with RPN #109, they stated that resident #027's treatment was listed on the eMAR for completion at one frequency, and that RPNs were required document completion of the treatment on the eMARs. The RPN identified that registered nursing staff were required to inform PSWs of the residents who required specific treatments and provide the treatments to the PSWs for completion that shift. The RPN reviewed the RPN 24 Hour Report [which listed specific treatments required for residents] and stated that the ordered treatment was not included with the treatments to be delegated to the PSWs on multiple dates in the winter of 2019, but should have been.

The Inspector reviewed the listed treatments on the RPN 24 Hour Report and confirmed that the treatment ordered for use at a specific frequency [which would have occurred on multiple dates in the winter of 2019] was not listed on any of the reports.

(b) The Inspector reviewed the Physician Review dated the winter of 2018, which indicated a treatment was to be completed to resident #027 at a specific frequency.

During an interview with PSW #108, they stated they knew that a treatment was ordered if the RPN told them to complete it. The PSW stated they completed the treatment at one frequency and at a greater frequency, if the resident exhibited a specific characteristic.

During an interview with RPN #109, they identified that the resident's treatment was listed on the eMARs. The RPN identified that registered nursing staff were required to inform PSWs of the residents who required treatments and hand out treatments to the PSWs for completion that shift. The RPN reviewed the RPN 24 Hour Report and stated

that the ordered treatment was not included with the treatments to be delegated to the PSWs on multiple dates in the winter of 2019, but should have been.

The Inspector reviewed the listed treatments on the RPN 24 Hour Report and confirmed that the treatment ordered for use another specific frequency [which had occurred on a date in the winter of 2019] was not listed on that date's report.

In summary, the licensee failed to ensure that plan of care provided clear directions to staff with respect to resident #027's use of ordered treatments, as both were not listed on the RPN 24 Hour Reports as per home's process for delegation of completion of the treatments to PSWs, and the eMAR contained conflicting information as to the frequency of completion of a treatment. [s. 6. (1) (c)]

4. During the inspection, resident #004 was observed by Inspectors #625 and #742 to request assistance on multiple dates.

(a) Inspectors #625 and #742 observed resident #004 request assistance on a date in the winter of 2019.

During an interview with the Inspectors, resident #004 stated they required assistance with toileting.

During an interview with Inspector #742 about resident #004's request related to toileting, PSW #110 stated to the Inspector that the resident could be toileted in a specific manner.

During an interview with the Administrator about resident #004's request related to toileting, the Administrator identified that PSW #110 was to toilet resident #004 as detailed in their care plan. The PSW then assisted the resident with toileting in a certain manner.

Inspector #625 reviewed resident #004's current care plan with a focus on toileting, and noted references to the resident's use of different toileting methods, including:
- staff were to assist the resident with toileting at a specific frequencies using one toileting method;
- the resident was to use a second toileting method for a specific reason;
- the resident was to use the second toileting method for a specific purpose and a third toileting method at a particular time;
- the resident was to use the second toileting method at specific times of the day; and

- a reference to the resident's use of the third toileting method.

During an interview with DOC #101, they stated that staff were to assist resident #004 with toileting using the second method of toileting, for a specific reason, before the resident used any other toileting methods. The DOC acknowledged that the resident's plan of care did not provide clear directions regarding resident #004's toileting methods.

(b) Inspectors #625 and #742 observed resident #004 request assistance at a particular time, on a particular date in the winter of 2019. At another particular time, the Inspector's observed PSW #110 provide the resident with assistance to transfer.

Inspector #625 reviewed resident #004's current care plan and noted an intervention created on a date in the winter of 2019, that identified the resident was to follow a specific intervention related to eating and dining.

During interviews with the Inspectors, PSW #110 stated that they had assisted resident #004 to eat and dine in a manner other than that identified in their current care plan. They reviewed the Kardex for resident #004, printed on a date in the winter of 2018, and located in the PSW binder on their care cart. The PSW stated the care plan did not include the intervention for the resident related to eating and dining.

The Inspectors then reviewed the care plan accessible to staff in the resident's chart. It also did not include reference to resident #004 eating and dining intervention, as it had not been replaced since the electronic version had been updated.

During an interview with Inspector #625, RAI Coordinator #105 stated that staff were supposed to replace the Kardex in the PSW binders and the care plans in the residents' charts with new ones, when they made changes to them.

During an interview with Inspector #625, DOC # 101 stated that the care plan in the resident's chart and the Kardex in the PSW binder both should have been changed with the updated version on the date the care plan was updated in the winter of 2019, and that the night staff were responsible for that action.

(c) During the review of resident #004's care plan effective and printed on two specific dates in the winter of 2018/2019, Inspector #625 noted that the care plan identified staff were to provide resident #004 with a minimum of two different amounts of fluid per day. [s. 6. (1) (c)]

5. A CIS report was submitted to the Director for an incident of improper or incompetent care of resident #008 which resulted in harm or a risk of harm to the resident. The CIS report identified that resident #008 was administered a supplement by RPN #111 on a date in the summer of 2018, which had not been the required fluid consistency identified in the resident’s plan of care.

Inspector #625 reviewed resident #008’s health care record including:
- An order by RD #103 dated the summer of 2018, to discontinue one type of supplement and initiate a second type of supplement of a specific consistency;
- the eMAR for one month in 2018, which listed the first type of supplement had been given 53 per cent of the times scheduled, after the date the RD order to change the supplement was written, but did not list the second supplement type; and
- the eMAR for a second month in 2018, which listed the first supplement type had been given 19 per cent of the time scheduled until it was discontinued on a date later that month [multiple weeks after the RD order to discontinue the supplement was written].
- the eMAR for a third month in 2018, which listed the initiation and documentation of administration of the second supplement type of a specific consistency on the eMAR beginning on a date that month [multiple weeks after the RD order to initiate the second supplement was written].

The Inspector also noted that the resident’s care plans in place as of a date in the summer of 2018, to a date in the winter of 2018, identified the resident had no difficulty swallowing, as well as identified the resident had swallowing difficulty.

During an interview with RPN #112, they reviewed the RD order dated the summer of 2018, and the eMARs for two months in 2018. The RPN stated the eMARs did not reflect that first supplement type was discontinued and the second supplement type was ordered on the date of the RD order. The RPN stated that the eMAR had not been clear with respect to the supplement staff were to give the resident which resulted in the first type of supplement continuing to be administered after the order had changed.

During an interview with DOC #102, they acknowledged that resident #008’s eMARs had not been clear to staff that they were to no longer provide the resident with the first type of supplement but were to provide a second type of supplement of a specific consistency beginning on the date of the RD order. The DOC also acknowledged that the resident’s two most recent care plans were not clear as to whether the resident had or did not have swallowing difficulty. [s. 6. (1) (c)]

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

CO #001 was issued from inspection #2018_616542_0015 pursuant to the LTCHA, 2007, s. 6 (9) 1.

The order required the licensee to ensure that the following were completed and implemented:
a) a review of the home's current documentation regarding Dietary Intake Reports and the Treatment Administration Records (TARs) to ensure that all staff were documenting the provision of care consistently and accurately; and
b) an effective auditing process of the Dietary Intake Reports and the TARs to ensure compliance.

The compliance due date for the order was November 16, 2018.

(A) With respect to steps (a) and (b) of the order, with a focus on the Dietary Reports containing documentation of the provision of care consistently and accurately, and auditing the home had in place to ensure compliance, Inspector #625 reviewed Dietary Reports from November 16, 2018, to January 10, 2019.

Resident #016 had the following documentation missing:
- breakfast on November 25, 26, December 1 and 20;
- AM snack on November 26, December 1, 2, 3, 5 and 11;
- lunch on November 18 and December 1;
- PM snack on November 24, 25, December 1, 2, 17, 22, 25, January 1 and 4;
- supper on December 4, 12 and 27; and
- HS snack on November 17, December 4 and 14.

Resident #026 had the following documentation missing:
- AM snack on December 1, 3, 11 and January 9;
- PM snack on November 18, 24 and 25;
- supper on November 17 and January 4; and
- HS snack on November 17, 21, 22, December 8 and 10.

Resident #033 had the following documentation missing:
- breakfast on November 19, December 1 and 27;

- AM snack on December 1, 27 and January 3;
- lunch on December 1 and 27;
- PM snack on December 1, 27 and January 3; and
- HS snack on December 9.

Inspector #625 interviewed RAI Coordinator #105 who acknowledged that residents #016, #026 and #033 had undocumented meal and snack items on the Dietary Reports reviewed by the Inspector. The RAI Coordinator stated that each meal or snack should have been documented, even if the meal was refused, the resident was on a leave of absence, etc. so there should be no blank areas.

During an interview with DOC #101, they reviewed Dietary Reports for residents #016, #026 and #033 and acknowledged that, since the compliance due date, there was missing documentation for various meals and snacks.

During an interview with the Administrator, they reviewed the Dietary Reports for residents #016, #026 and #033 and acknowledged that the residents had missing documentation for various meals and snacks. The Administrator stated that staff should document something for each meal and snack, such as whether the resident was sleeping, refused, was on a leave of absence, etc. and that the Dietary Report review conducted by the Inspector was consistent with the audit findings completed by the home with respect to missing resident meal and snack documentation.

(B) With respect to steps (a) and (b) of the order, with a focus on the eTARs containing documentation of the provision of care consistently and accurately, and auditing the home had in place to ensure compliance, the Inspector reviewed eMARs and eTARs from November 16, 2018, to January 10, 2019, as registered nursing staff and DOC #101 had informed the Inspector that treatments had been moved from the eTARs to the eMARs.

(i) Inspector #625 reviewed current Physician's orders for resident #028 which included an order dated in the fall of 2018, for a treatment for the resident at a specified frequency and duration.

A review of the eMAR/eTAR identified the treatment was scheduled at a specific frequency, at specified times, over multiple dates. Documentation of the completion of the treatment on a date in the fall of 2018, at a specific time, did not reflect that the treatment had occurred as it continued to reflect that the treatment was still "scheduled"

A review of the Flow Sheets completed by PSWs identified a PSW completed the resident's treatment on a date and shift that corresponded to the eMAR/eTAR entry that reflected the treatment was still "scheduled".

The Inspector noted the undocumented eMAR/eTAR entry dated the fall of 2018, at a specific time, did not reflect the completion of the treatment signed for by a PSW on the Flow Sheet on the corresponding date and shift.

During an interview with DOC #101, they acknowledged that the eMAR for resident #028's treatment order dated in the fall of 2018, included a scheduled application time on a specific date that had not been documented, which had not been included in the audit.

The Inspector reviewed the home's audit for multiple specific dates, and noted that it did not list resident #028 as having a treatment during that time.

The Inspector also noted, although the order compliance due date was November 16, 2018, the first eMAR/eTAR audit completed by the home was for the period from November 23 to 30, 2018, and was conducted on November 30, 2018.

(ii) Inspector #625 reviewed a subsequent Physician's orders for resident #028 which included an order dated the winter of 2018, for a treatment at a specific frequency for a specific duration.

A review of the eMAR/eTAR identified the treatment ordered in the fall of 2018, was scheduled to be provided at specific times between specific dates and times. No other treatments of that type were listed for the resident during that month. The provision of the treatment had not been documented during any of the multiple application dates and times.

A review of the Flow Sheets completed by PSWs did not include any documentation that the treatment had been provided any time during the month it was required in 2018.

During an interview with RN #107, they stated that the treatment ordered in the fall of 2018 had been placed on the eTAR by pharmacy after the home had moved all residents' treatments to the eMARs.

During an interview with DOC #101, they acknowledged that the treatment ordered in the

fall of 2018 had not been documented as provided on the eTAR/eMAR for multiple consecutive dates it was required, and stated they were not sure if it had been captured on an audit.

The Inspector reviewed the home's audit for a period of time in the fall of 2018, and noted that it did not list resident #028 as having the treatment ordered during this time. [The home had not conducted an audit of the other dates in the fall of 2018, when the treatment had been required.]

(iii) Inspector #625 reviewed current Physician's orders for resident #027 which included orders commencing on a date in the fall of 2018, covering the review period ending on a date in the winter of 2019, for a treatment to be completed at a specified frequency, related to a specific activity of daily living (ADL).

A review of the eMAR/eTAR identified the treatment was scheduled to be administered on multiple specific dates in the fall of 2018 and winter of 2018/2019. The provision of the treatment was not documented and continued to reflect "s" indicating the application was still scheduled.

The Flow Sheets identified the resident had the treatment completed on multiple specific dates in the fall of 2018 and the winter of 2018/2019.

The Inspector noted that undocumented eMAR/eTAR entries dated on multiple specific dates in the fall of 2018 and winter of 2019 did not reflect that the treatment had been provided as signed for by a PSW on the Flow Sheet on those dates.

During an interview with PSW #108, they stated that they provided the resident with the treatment related to an ADL and documented the provision of the treatment on the Flow Sheet when it was provided to the resident.

During an interview with RPN #109, they reviewed eMARs/eTARs for two months in the winter of 2018/2019, and acknowledged that there were multiple unsigned treatment entries in each month. The RPN stated that each entry should have been documented, even if the treatment had not been provided.

During an interview with DOC #101, they stated that the treatment should have been signed by the RPNs in the eMAR. The DOC acknowledged multiple dates in two months in the winter of 2018/2019 where the treatment had not been documented in the eMAR.

The Inspector reviewed the home's completed audits of the eMARs and noted:
- the audit for a period of time in the fall of 2018, identified resident #027 required the treatment at a specific frequency;
- the audit for a second period of time in the fall of 2018, identified resident #027 required two different treatments, neither of which were ordered for the resident. The audit did not identify the resident used the ordered treatment, and did not include an audit of the resident's topical treatments; and
- the audit for a third and a fourth period in the winter of 2018/2019, did not list resident #027 as having any treatments, although the treatment was ordered for the resident at that time.

(iv) Inspector #625 reviewed current Physician's orders for resident #027 which included Physician's orders dated the fall of 2018, for a treatment to be completed at a specified frequency, and related to a specific ADL. The review identified this order had started on a date in the spring of 2018, and covered the review period ending in the winter of 2019.

A review of the eMARs/eTARs identified the treatment was scheduled to be performed at a specific frequency from a date in the fall of 2018, to a date in the winter of 2019, as well as related to a specific ADL during the same period. The provision of the treatment was not documented and continued to reflect "s" indicating the treatment was still scheduled and had not been documented for 95 per cent of the entries that directed staff to perform the treatment at a specific frequency, and related to a specific ADL.

Although the resident had the ADL documented on multiple dates during the review period, the eMARs/eTARs only contained documentation that the treatment had been provided on 7 per cent of the occasions when the ADL occurred.

During an interview with RPN #109, they reviewed the eMARs and acknowledged that the treatment was present for the RPNs to sign but that they were not sure if it had been provided at the frequency ordered. The RPN acknowledged that the treatment had been signed, from November 16, 2018, to January 10, 2019, a certain number of times. The RPN stated that RPNs should have documented if the treatment had been provided, provided by PSWs, etc.

During an interview with DOC #101, they acknowledged that the treatment had been ordered by a Physician for resident #027 and that the eMAR identified it was to be applied at a specific frequency, and related to a specific ADL.

The Inspector reviewed the home’s completed audits of the eMARs and noted:
- the audit for a period of time in the fall of 2018, identified that resident #027 performed the treatment and there was no documentation of the treatment for multiple days the audit covered. The audit noted the resident performed the treatment themself;
- the audit for a second period of time in the fall of 2018, identified that resident #027 required two different treatments, neither of which were ordered for the resident. The audit did not identify the resident used the ordered treatment, and did not include an audit of the resident’s topical treatments; and
- the audit for a third and a fourth period in the winter of 2018/2019, did not list resident #027 as having any treatments, although the treatment was ordered for the resident at that time.

In conclusion, the home had failed to review current documentation regarding eTARs/eMARs to ensure that all staff were documenting the provision of care consistently and accurately, and that an effective auditing process of the eTARs/eMARs was completed and implemented to ensure compliance. Although the home had implemented an auditing process for topical treatments moved to the eMARs, the home had failed to ensure the auditing identified and addressed a lack of documentation. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.
DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with directions for use specified by the prescriber.

CO #001 was issued from inspection #2018_616542_0015. During inspection of CO #001, Inspector #625 identified non-compliance pursuant to O. Reg. 79/10, s. 131 (2).

During a review of eTARs/eMARs records for resident #028 from November 16, 2018, to January 10, 2019, Inspector #625 identified an entry for a topical drug, for a specific duration, from specific dates and times.

The Inspector reviewed the corresponding Physician's order dated the fall of 2018, which directed staff to continue with the topical drug previously ordered and last administered the previous month.

The Inspector reviewed resident #028's PSW Flow Sheet for a month in 2018, which did not list the provision of the topical drug by a PSW on any date during that month.

During an interview with RPN #106, they reviewed resident #028's eMAR/eTAR and acknowledged it did not indicate that the topical drug had been provided to the resident during a specific month in 2018. The RPN could not find a record indicating that the topical drug had been received in the Drug Record Book, and contacted the pharmacy provider whose representative informed the RPN that the topical drug ordered on a date in the fall of 2018, had not been sent to the home from the pharmacy. The RPN stated the topical drug had not been provided to the resident.

During interviews with DOC #101, they reviewed the eMARs/eTARs and acknowledged that the application of resident #028's topical drug was not identified in the record. The DOC confirmed that resident #028 had not received the topical drug as ordered. [s. 131. (2)]

2. CIS reports were received by the Director on dates in the spring, summer and fall of 2018. The reports identified missing drugs for resident #002.

(a) Inspector #742 reviewed a Physician's order dated the spring of 2018, for resident #002, which directed staff to provide the resident with the drug at a specific frequency. Subsequent Physician's orders also identified the drug was to be provided to the resident at the specific frequency.

A review of the eMARs identified periods of time where the drug had not been provided to the resident at the specified frequency, on multiple occasions.

A progress note dated the fall of 2018, indicated that resident #002's drug count had not changed for multiple days. The resident's drug was due to be provided on a date in the summer of 2018, but was not provided until multiple days later.

During an interview with Inspector #625, RPN #113 acknowledged that the eMAR did not indicate that the drug had been provided to resident #002 over multiple days, on multiple occasions in the spring and summer of 2018. The RPN acknowledged that the eMAR contained no documentation which identified that the drug had been provided to the resident during those periods of time, at the frequency ordered by the prescriber.

During an interview with Inspector #625, RN #114 reviewed the progress note dated the fall of 2018, which identified that the drug count had not changed for multiple days, and the last time the drug was provided to the resident was documented on a date in the summer of 2018. The RN acknowledged that, according to the documentation, the drug had not been provided to the resident in accordance with prescriber's directions.

During an interview with Inspector #625, DOC #101 reviewed resident #002's health record and acknowledged that the drug had not been provided for multiple dates in the summer of 2018. The DOC acknowledged that resident #002 had not had the drug provided at the frequency ordered by the Physician.

(b) Inspector #742 reviewed resident #002's Medication Reconciliation Physician Reviews dated during four different months in 2018, which directed staff to check the resident's drug application at a specific frequency.

During a review of resident #002's eMARs, multiple drug checks required at a specific frequency from a month in 2018, to a month in 2019, reflected that the checks were still

scheduled and were not documented as completed:
- on multiple occasions in one month;
- on multiple occasions in another month;
- on multiple occasions in another month;
- on multiple occasions in another month;
- on multiple occasions in another month;
- on multiple occasions in another month;
- on an occasion in another month; and
- on multiple occasions in another month.

Additional occasions during the review period reflected that the drug checks were "Not Delivered".

During an interview with Inspector #625, RPN #115 stated that if the eMAR indicated an "S" [scheduled] or "N" [not delivered] during medication checks, the signified staff had not completed the checks. The RPN reviewed resident #002's eMARs and acknowledged that all of the drug checks scheduled had not been completed in accordance with the Physician's orders.

In an interview with Inspector #625, RN #114 stated that if the Physician identified that the drug was to be checked at a specific frequency, and it was marked as not delivered or not signed as done, the drug had not been checked as the Physician directed.

In an interview with Inspector #625, DOC #101 acknowledged that there were multiple drug checks for resident #002 which had not been completed; and consequently, the prescriber's orders had not been followed.

(c) Inspector #742 reviewed resident #002's Medication Reconciliation Physician Reviews dated during four different months in 2018, which directed staff to remove one drug prior to the provision of a new drug. Two of the reviews also directed staff to document the removal of the previous drug in the eMAR.

During a review of resident #002's eMARs from May 1, 2018, to January 9, 2019, with a focus on the removal of the previous drug prior to the provision of a new drug, Inspectors #625 and #742 identified multiple times where the removal of the prior drug before the provision of the new drug had not been documented. These included multiple removals that had not been documented in the fall of 2018.

A review of resident #002's progress notes identified a note detailing that a drug

continued to be provided to resident #002 on a date after it had been scheduled to be changed in the summer of 2018.

A review of medication incident reports contained details consistent with the details in the reviewed progress note.

In an interview with Inspector #625, RN #107 acknowledged that resident #002’s drug provided on a date in the summer of 2018, had not been removed as required on a specific date that month, but remained in place until the following date.

During an interview with Inspector #625, DOC #101 stated that staff were required to remove previous drug prior to providing a new drug, in accordance with the prescriber’s directions. [s. 131. (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 that ensures that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 14th day of February, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : KATHERINE BARCA (625), SHARON GOERTZEN (742)

Inspection No. / No de l'inspection : 2019_703625_0002

Log No. / No de registre : 027244-18, 027245-18

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Feb 8, 2019

Licensee / Titulaire de permis : St. Joseph's Care Group
35 North Algoma Street, P.O. Box 3251, THUNDER BAY, ON, P7B-5G7

LTC Home / Foyer de SLD : Bethammi Nursing Home
63 Carrie Street, THUNDER BAY, ON, P7A-4J2

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Janine Black

To St. Joseph's Care Group, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_616542_0015, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with s. 6 (1) of the LTCHA, 2007.

The licensee shall ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Specifically, the licensee must:
a) Review and update, as required, resident #006's and resident #007's plans of care, with a focus on nutrition and dietary interventions, to ensure the written plans set out clear directions to staff and others who provide direct care to the residents.
b) Identify the residents in the home who are at risk of choking and require related nutrition and dietary interventions. Ensure the plans of care for those residents provide clear directions with respect to nutrition, dietary and supplement related interventions.
c) Review and update, as required, resident #028's plan of care, with a focus on treatments ordered, to ensure the written plan sets out clear directions to staff and others who provide direct care to the resident.
d) Review and update, as required, resident #027's plan of care, with a focus on treatment orders and topical drug use, to ensure the written plan sets out clear directions to staff and others who provide direct care to the resident.
e) Review and update, as required, resident #004's plan of care, with a focus on toileting, dining and dietary interventions, to ensure the written plan sets out clear directions to staff and others who provide direct care to the resident.
f) Maintain written records of the reviews completed in steps (a) to (e), including the dates of the reviews, the names and classifications of the staff involved in the reviews, the documents updated and any changes made.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

Compliance Order (CO) #002 was issued from inspection #2018_616542_0015 pursuant to the Long-Term Care Homes Act (LTCHA), 2007, s. 6 (1) (c). The order required the licensee to be compliant with s. 6 (1) (c) of the LTCHA. The compliance due date was October 26, 2018.

Inspector #625 reviewed documents pertaining to CO #002 provided by the home including a document titled Bethammi High Choke Risk List January 2019. The list identified residents #006 and #007 had been assessed as being at risk to choke.

(a) The Inspector reviewed resident #006's current care plan and Kardex. Both documents identified the resident as a choke risk and listed the resident's diet texture as two different textures.

During an interview with RD #103, they reviewed resident #006's care plan and Kardex and acknowledged that the plan of care was unclear regarding the resident's diet texture.

During an interview with the Administrator, they reviewed resident #006's current care plan and Kardex and acknowledged that the resident's plan of care did not provide clear direction with respect to the resident's diet texture.

(b) The Inspector also reviewed resident #007's current care plan and Kardex. Both documents identified the resident as being at risk to choke and identified the resident:
- required two different diet textures;
- required fluids of two different consistencies;
- required two different minimum fluid requirements per day; and
- staff were to encourage the resident to drink fluids, and listed specific beverages the resident liked to drink. However, elsewhere the documents indicated that staff were to limit one of the specific beverages liked by the resident.

Resident #007's current care plan also identified expected outcomes for resident #007 as both maintaining their current body weight/changing their weight towards a body weight within one range in the next three months, and as consuming adequate nutrition to maintain their weight within a different range.

The care plan identified the resident's body mass index (BMI) as two different values; while the Kardex listed the resident's BMI as a third value.

During an interview with RD #103, they reviewed the care plan and Kardex for resident #007 and acknowledged that the plan of care was unclear regarding the resident's required diet texture, fluid consistency, minimum daily fluid requirement, ingestion of a particular beverage, weight goals and BMI.

During an interview with the Administrator, they reviewed resident #007's current care plan and Kardex and acknowledged that the resident's plan of care did not provide clear direction with respect to the resident's required diet texture, fluid consistency, minimum daily fluid requirement, ingestion of juices, weight goals and BMI. (625)

2. CO #001 was issued from inspection #2018_616542_0015. During inspection of CO #001, Inspector #625 identified non-compliance pursuant to the LTCHA, 2007, s. 6 (1)(c).

(a) During a review of eTARs/eMARs for resident #028 from November 16, 2018, to January 10, 2019, Inspector #625 noted an entry for a treatment to the resident.

During interviews with resident #028, they stated that they used the treatment.

During an interview with PSW #104, they stated that they had known and provided care to resident #028 for a period of time, and the resident used the treatment.

During an interview with RPN #106, they stated they were familiar with resident #028 but did not believe the resident had the treatment as they had never signed for it on the eMAR/eTAR.

During an interview with RAI Coordinator #105, they contacted the pharmacy provider about resident #028's treatment. The RAI Coordinator stated the pharmacy had informed the RAI Coordinator that the order had been incorrectly entered as an eMAR note and not as a treatment order and, as a result, registered staff had not been able to view the treatment as an order to be completed.

(b) During a review of eTARs/eMARs for resident #028 from November 16,

2018, to January 10, 2019, Inspector #625 noted an entry for a treatment for multiple dates. The entry did not reflect that the treatment had been provided to the resident.

During an interview with RN #107, they stated that resident #028's treatment had been entered onto the eTAR by the pharmacy provider, after the home had been relying exclusively on the eMAR, which resulted in the order on the eTAR being unseen by registered nursing staff.

During an interview with the DOC, they reviewed the eMAR/eTAR and acknowledged that all treatments of a specific characteristic should have been moved from the eTAR to the eMAR, as the home no longer referred to the eTAR for treatments.

In summary, the licensee failed to ensure that the plan of care provided clear directions to staff with respect to resident #028's use of one treatment that was not listed on the eMAR/eTAR in the manner required for staff to be aware of and document its use; and a second treatment, which had been entered by the pharmacy on the eTAR, after the home had transitioned to using the eMAR as the exclusive document for all treatments.
e had transitioned to using the eMAR as the exclusive document for all treatments. (625)

3. CO #001 was issued from inspection #2018_616542_0015. During inspection of CO #001, Inspector #625 identified non-compliance pursuant to the LTCHA, 2007, s. 6 (1)(c).

(a) Inspector #625 reviewed the eTAR/eMAR for resident #027 from November 16, 2018, to January 9, 2019, and noted multiple entries for the same treatment. One entry identified the treatment was to be done at a specific frequency, while the another entry listed the treatment was to be done at a different frequency.

The Inspector reviewed a Physician Review from the winter of 2018, which indicated the treatment was to be done at a specific frequency. The treatment orders did not identify the treatment was to be done at the other frequency listed in the eMAR/eTAR.

During an interview with PSW #108, they stated they knew that a specific treatment was ordered if the RPN told them to complete the treatment. The PSW stated they had completed the treatment to resident #027 at a frequency that differed from the previous two frequencies listed on the eMAR/eTAR, but had not been aware that it was a Physician's order. The PSW reviewed the eMAR entries for the treatment and acknowledged the entries were not clear as to whether the treatment was to be completed at one frequency, or at another frequency.

During an interview with RPN #109, they stated that resident #027's treatment was listed on the eMAR for completion at one frequency, and that RPNs were required document completion of the treatment on the eMARs. The RPN identified that registered nursing staff were required to inform PSWs of the residents who required specific treatments and provide the treatments to the PSWs for completion that shift. The RPN reviewed the RPN 24 Hour Report [which listed specific treatments required for residents] and stated that the ordered treatment was not included with the treatments to be delegated to the PSWs on multiple dates in the winter of 2019, but should have been.

The Inspector reviewed the listed treatments on the RPN 24 Hour Report and confirmed that the treatment ordered for use at a specific frequency [which would have occurred on multiple dates in the winter of 2019] was not listed on any of the reports.

(b) The Inspector reviewed the Physician Review dated the winter of 2018, which indicated a treatment was to be completed to resident #027 at a specific frequency.

During an interview with PSW #108, they stated they knew that a treatment was ordered if the RPN told them to complete it. The PSW stated they completed the treatment at one frequency and at a greater frequency, if the resident exhibited a specific characteristic.

During an interview with RPN #109, they identified that the resident's treatment was listed on the eMARs. The RPN identified that registered nursing staff were required to inform PSWs of the residents who required treatments and hand out treatments to the PSWs for completion that shift. The RPN reviewed the RPN 24

Hour Report and stated that the ordered treatment was not included with the treatments to be delegated to the PSWs on multiple dates in the winter of 2019, but should have been.

The Inspector reviewed the listed treatments on the RPN 24 Hour Report and confirmed that the treatment ordered for use another specific frequency [which had occurred on a date in the winter of 2019] was not listed on that date's report.

In summary, the licensee failed to ensure that plan of care provided clear directions to staff with respect to resident #027's use of ordered treatments, as both were not listed on the RPN 24 Hour Reports as per home's process for delegation of completion of the treatments to PSWs, and the eMAR contained conflicting information as to the frequency of completion of a treatment. (625)

4. During the inspection, resident #004 was observed by Inspectors #625 and #742 to request assistance on multiple dates.

(a) Inspectors #625 and #742 observed resident #004 request assistance on a date in the winter of 2019.

During an interview with the Inspectors, resident #004 stated they required assistance with toileting.

During an interview with Inspector #742 about resident #004's request related to toileting, PSW #110 stated to the Inspector that the resident could be toileted in a specific manner.

During an interview with the Administrator about resident #004's request related to toileting, the Administrator identified that PSW #110 was to toilet resident #004 as detailed in their care plan. The PSW then assisted the resident with toileting in a certain manner.

Inspector #625 reviewed resident #004's current care plan with a focus on toileting, and noted references to the resident's use of different toileting methods, including:
- staff were to assist the resident with toileting at a specific frequencies using one toileting method;

- the resident was to use a second toileting method for a specific reason;
- the resident was to use the second toileting method for a specific purpose and a third toileting method at a particular time;
- the resident was to use the second toileting method at specific times of the day; and
- a reference to the resident's use of the third toileting method.

During an interview with DOC #101, they stated that staff were to assist resident #004 with toileting using the second method of toileting, for a specific reason, before the resident used any other toileting methods. The DOC acknowledged that the resident's plan of care did not provide clear directions regarding resident #004's toileting methods.

(b) Inspectors #625 and #742 observed resident #004 request assistance at a particular time, on a particular date in the winter of 2019. At another particular time, the Inspector's observed PSW #110 provide the resident with assistance to transfer.

Inspector #625 reviewed resident #004's current care plan and noted an intervention created on a date in the winter of 2019, that identified the resident was to follow a specific intervention related to eating and dining.

During interviews with the Inspectors, PSW #110 stated that they had assisted resident #004 to eat and dine in a manner other than that identified in their current care plan. They reviewed the Kardex for resident #004, printed on a date in the winter of 2018, and located in the PSW binder on their care cart. The PSW stated the care plan did not include the intervention for the resident related to eating and dining.

The Inspectors then reviewed the care plan accessible to staff in the resident's chart. It also did not include reference to resident #004 eating and dining intervention, as it had not been replaced since the electronic version had been updated.

During an interview with Inspector #625, RAI Coordinator #105 stated that staff were supposed to replace the Kardex in the PSW binders and the care plans in the residents' charts with new ones, when they made changes to them.

During an interview with Inspector #625, DOC # 101 stated that the care plan in the resident's chart and the Kardex in the PSW binder both should have been changed with the updated version on the date the care plan was updated in the winter of 2019, and that the night staff were responsible for that action.

(c) During the review of resident #004's care plan effective and printed on two specific dates in the winter of 2018/2019, Inspector #625 noted that the care plan identified staff were to provide resident #004 with a minimum of two different amounts of fluid per day. (625)

5. A CIS report was submitted to the Director for an incident of improper or incompetent care of resident #008 which resulted in harm or a risk of harm to the resident. The CIS report identified that resident #008 was administered a supplement by RPN #111 on a date in the summer of 2018, which had not been the required fluid consistency identified in the resident's plan of care.

Inspector #625 reviewed resident #008's health care record including:
- An order by RD #103 dated the summer of 2018, to discontinue one type of supplement and initiate a second type of supplement of a specific consistency;
- the eMAR for one month in 2018, which listed the first type of supplement had been given 53 per cent of the times scheduled, after the date the RD order to change the supplement was written, but did not list the second supplement type; and
- the eMAR for a second month in 2018, which listed the first supplement type had been given 19 per cent of the time scheduled until it was discontinued on a date later that month [multiple weeks after the RD order to discontinue the supplement was written].
- the eMAR for a third month in 2018, which listed the initiation and documentation of administration of the second supplement type of a specific consistency on the eMAR beginning on a date that month [multiple weeks after the RD order to initiate the second supplement was written].

The Inspector also noted that the resident's care plans in place as of a date in the summer of 2018, to a date in the winter of 2018, identified the resident had no difficulty swallowing, as well as identified the resident had swallowing difficulty.

During an interview with RPN #112, they reviewed the RD order dated the summer of 2018, and the eMARs for two months in 2018. The RPN stated the eMARs did not reflect that first supplement type was discontinued and the second supplement type was ordered on the date of the RD order. The RPN stated that the eMAR had not been clear with respect to the supplement staff were to give the resident which resulted in the first type of supplement continuing to be administered after the order had changed.

During an interview with DOC #102, they acknowledged that resident #008's eMARs had not been clear to staff that they were to no longer provide the resident with the first type of supplement but were to provide a second type of supplement of a specific consistency beginning on the date of the RD order. The DOC also acknowledged that the resident's two most recent care plans were not clear as to whether the resident had or did not have swallowing difficulty.

The decision to issue a compliance order was based on the severity level 2, where there was the potential for actual harm to occur; and the scope level 2, as a pattern of non-compliance was identified. The home has a compliance history level 4 as, despite Ministry of Health and Long-Term Care action, non-compliance continues in this area of the legislation. The home's compliance history in this specific area of the legislation includes:
- CO #002 issued in report #2018_616542_0015 on September 24, 2018, with a compliance date of October 26, 2018;
- CO #001 issued in report #2018_703625_0006 on April 13, 2018, with a compliance date of May 31, 2018; and
- a voluntary plan of correction (VPC) issued in report #2018_703625_0001 on March 26, 2018. (625)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 05, 2019

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2018_616542_0015, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 6 (9) of the LTCHA, 2007.

The licensee shall ensure that the provision of care set out in the plan of care is documented.

Specifically, the licensee must:
a) Conduct a review of the Dietary Reports, Treatment Administration Records (TARs) and Medication Administration Records (MARs), to ensure staff are documenting the provision of care consistently and accurately.
b) Develop a process for staff to adhere to when the completion of documentation is required following the shift on which it occurred.
c) Establish an effective auditing process of the Dietary Reports, TARs and MARs.
d) Maintain records of the audits conducted, including the dates of the audits, the names and classifications of the staff involved in the audits, the audit findings and corrective actions taken to address any deficiencies in documentation identified.

Grounds / Motifs :

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

CO #001 was issued from inspection #2018_616542_0015 pursuant to the LTCHA, 2007, s. 6 (9) 1.

The order required the licensee to ensure that the following were completed and implemented:
a) a review of the home's current documentation regarding Dietary Intake Reports and the Treatment Administration Records (TARs) to ensure that all staff were documenting the provision of care consistently and accurately; and
b) an effective auditing process of the Dietary Intake Reports and the TARs to ensure compliance.

The compliance due date for the order was November 16, 2018.

(A) With respect to steps (a) and (b) of the order, with a focus on the Dietary Reports containing documentation of the provision of care consistently and accurately, and auditing the home had in place to ensure compliance, Inspector #625 reviewed Dietary Reports from November 16, 2018, to January 10, 2019.

Resident #016 had the following documentation missing:
- breakfast on November 25, 26, December 1 and 20;
- AM snack on November 26, December 1, 2, 3, 5 and 11;
- lunch on November 18 and December 1;
- PM snack on November 24, 25, December 1, 2, 17, 22, 25, January 1 and 4;
- supper on December 4, 12 and 27; and
- HS snack on November 17, December 4 and 14.

Resident #026 had the following documentation missing:
- AM snack on December 1, 3, 11 and January 9;
- PM snack on November 18, 24 and 25;
- supper on November 17 and January 4; and
- HS snack on November 17, 21, 22, December 8 and 10.

Resident #033 had the following documentation missing:
- breakfast on November 19, December 1 and 27;
- AM snack on December 1, 27 and January 3;
- lunch on December 1 and 27;
- PM snack on December 1, 27 and January 3; and

- HS snack on December 9.

Inspector #625 interviewed RAI Coordinator #105 who acknowledged that residents #016, #026 and #033 had undocumented meal and snack items on the Dietary Reports reviewed by the Inspector. The RAI Coordinator stated that each meal or snack should have been documented, even if the meal was refused, the resident was on a leave of absence, etc. so there should be no blank areas.

During an interview with DOC #101, they reviewed Dietary Reports for residents #016, #026 and #033 and acknowledged that, since the compliance due date, there was missing documentation for various meals and snacks.

During an interview with the Administrator, they reviewed the Dietary Reports for residents #016, #026 and #033 and acknowledged that the residents had missing documentation for various meals and snacks. The Administrator stated that staff should document something for each meal and snack, such as whether the resident was sleeping, refused, was on a leave of absence, etc. and that the Dietary Report review conducted by the Inspector was consistent with the audit findings completed by the home with respect to missing resident meal and snack documentation.

(B) With respect to steps (a) and (b) of the order, with a focus on the eTARs containing documentation of the provision of care consistently and accurately, and auditing the home had in place to ensure compliance, the Inspector reviewed eMARs and eTARs from November 16, 2018, to January 10, 2019, as registered nursing staff and DOC #101 had informed the Inspector that treatments had been moved from the eTARs to the eMARs.

(i) Inspector #625 reviewed current Physician's orders for resident #028 which included an order dated in the fall of 2018, for a treatment for the resident at a specified frequency and duration.

A review of the eMAR/eTAR identified the treatment was scheduled at a specific frequency, at specified times, over multiple dates. Documentation of the completion of the treatment on a date in the fall of 2018, at a specific time, did not reflect that the treatment had occurred as it continued to reflect that the

treatment was still "scheduled” to occur.

A review of the Flow Sheets completed by PSWs identified a PSW completed the resident's treatment on a date and shift that corresponded to the eMAR/eTAR entry that reflected the treatment was still "scheduled".

The Inspector noted the undocumented eMAR/eTAR entry dated the fall of 2018, at a specific time, did not reflect the completion of the treatment signed for by a PSW on the Flow Sheet on the corresponding date and shift.

During an interview with DOC #101, they acknowledged that the eMAR for resident #028’s treatment order dated in the fall of 2018, included a scheduled application time on a specific date that had not been documented, which had not been included in the audit.

The Inspector reviewed the home’s audit for multiple specific dates, and noted that it did not list resident #028 as having a treatment during that time.

The Inspector also noted, although the order compliance due date was November 16, 2018, the first eMAR/eTAR audit completed by the home was for the period from November 23 to 30, 2018, and was conducted on November 30, 2018.

(ii) Inspector #625 reviewed a subsequent Physician’s orders for resident #028 which included an order dated the winter of 2018, for a treatment at a specific frequency for a specific duration.

A review of the eMAR/eTAR identified the treatment ordered in the fall of 2018, was scheduled to be provided at specific times between specific dates and times. No other treatments of that type were listed for the resident during that month. The provision of the treatment had not been documented during any of the multiple application dates and times.

A review of the Flow Sheets completed by PSWs did not include any documentation that the treatment had been provided any time during the month it was required in 2018.

During an interview with RN #107, they stated that the treatment ordered in the fall of 2018 had been placed on the eTAR by pharmacy after the home had moved all residents' treatments to the eMARs.

During an interview with DOC #101, they acknowledged that the treatment ordered in the fall of 2018 had not been documented as provided on the eTAR/eMAR for multiple consecutive dates it was required, and stated they were not sure if it had been captured on an audit.

The Inspector reviewed the home's audit for a period of time in the fall of 2018, and noted that it did not list resident #028 as having the treatment ordered during this time. [The home had not conducted an audit of the other dates in the fall of 2018, when the treatment had been required.]

(iii) Inspector #625 reviewed current Physician's orders for resident #027 which included orders commencing on a date in the fall of 2018, covering the review period ending on a date in the winter of 2019, for a treatment to be completed at a specified frequency, related to a specific activity of daily living (ADL).

A review of the eMAR/eTAR identified the treatment was scheduled to be administered on multiple specific dates in the fall of 2018 and winter of 2018/2019. The provision of the treatment was not documented and continued to reflect "s" indicating the application was still scheduled.

The Flow Sheets identified the resident had the treatment completed on multiple specific dates in the fall of 2018 and the winter of 2018/2019.

The Inspector noted that undocumented eMAR/eTAR entries dated on multiple specific dates in the fall of 2018 and winter of 2019 did not reflect that the treatment had been provided as signed for by a PSW on the Flow Sheet on those dates.

During an interview with PSW #108, they stated that they provided the resident with the treatment related to an ADL and documented the provision of the treatment on the Flow Sheet when it was provided to the resident.

During an interview with RPN #109, they reviewed eMARs/eTARs for two

months in the winter of 2018/2019, and acknowledged that there were multiple unsigned treatment entries in each month. The RPN stated that each entry should have been documented, even if the treatment had not been provided.

During an interview with DOC #101, they stated that the treatment should have been signed by the RPNs in the eMAR. The DOC acknowledged multiple dates in two months in the winter of 2018/2019 where the treatment had not been documented in the eMAR.

The Inspector reviewed the home's completed audits of the eMARs and noted:
- the audit for a period of time in the fall of 2018, identified resident #027 required the treatment at a specific frequency;
- the audit for a second period of time in the fall of 2018, identified resident #027 required two different treatments, neither of which were ordered for the resident. The audit did not identify the resident used the ordered treatment, and did not include an audit of the resident's topical treatments; and
- the audit for a third and a fourth period in the winter of 2018/2019, did not list resident #027 as having any treatments, although the treatment was ordered for the resident at that time.

(iv) Inspector #625 reviewed current Physician's orders for resident #027 which included Physician's orders dated the fall of 2018, for a treatment to be completed at a specified frequency, and related to a specific ADL. The review identified this order had started on a date in the spring of 2018, and covered the review period ending in the winter of 2019.

A review of the eMARs/eTARs identified the treatment was scheduled to be performed at a specific frequency from a date in the fall of 2018, to a date in the winter of 2019, as well as related to a specific ADL during the same period. The provision of the treatment was not documented and continued to reflect "s" indicating the treatment was still scheduled and had not been documented for 95 per cent of the entries that directed staff to perform the treatment at a specific frequency, and related to a specific ADL.

Although the resident had the ADL documented on multiple dates during the review period, the eMARs/eTARs only contained documentation that the treatment had been provided on 7 per cent of the occasions when the ADL

occurred.

During an interview with RPN #109, they reviewed the eMARs and acknowledged that the treatment was present for the RPNs to sign but that they were not sure if it had been provided at the frequency ordered. The RPN acknowledged that the treatment had been signed, from November 16, 2018, to January 10, 2019, a certain number of times. The RPN stated that RPNs should have documented if the treatment had been provided, provided by PSWs, etc.

During an interview with DOC #101, they acknowledged that the treatment had been ordered by a Physician for resident #027 and that the eMAR identified it was to be applied at a specific frequency, and related to a specific ADL.

The Inspector reviewed the home's completed audits of the eMARs and noted:
- the audit for a period of time in the fall of 2018, identified that resident #027 performed the treatment and there was no documentation of the treatment for multiple days the audit covered. The audit noted the resident performed the treatment themself;
- the audit for a second period of time in the fall of 2018, identified that resident #027 required two different treatments, neither of which were ordered for the resident. The audit did not identify the resident used the ordered treatment, and did not include an audit of the resident's topical treatments; and
- the audit for a third and a fourth period in the winter of 2018/2019, did not list resident #027 as having any treatments, although the treatment was ordered for the resident at that time.

In conclusion, the home had failed to review current documentation regarding eTARs/eMARs to ensure that all staff were documenting the provision of care consistently and accurately, and that an effective auditing process of the eTARs/eMARs was completed and implemented to ensure compliance. Although the home had implemented an auditing process for topical treatments moved to the eMARs, the home had failed to ensure the auditing identified and addressed a lack of documentation.

The decision to issue this compliance order was based on the severity level 2, where there was the potential for actual harm to occur; and the scope level 2, as a pattern of non-compliance was identified. The home has a compliance history

level 4 as, despite Ministry of Health and Long-Term Care action, non-compliance continues in this area of the legislation. The home's compliance history in this specific area of the legislation includes:
- CO #001 issued in report #2018_616542_0015 on September 24, 2018, with a compliance date of November 16, 2018;
- a written notification (WN) issued in report #2018_703625_0006 on April 13, 2018;
- CO #001 issued in report #2018_703625_0001 on March 26, 2018, with a compliance date of June 30, 2018; and
- a VPC issued in report #2017_463616_0007 on August 2, 2017. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 05, 2019

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 8th day of February, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Katherine Barca

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