Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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

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

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 10, 2019	2019_768693_0005 (A2)	004151-19	Resident Quality Inspection

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street 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

Amended by RYAN GOODMURPHY (638) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Amendment of the compliance due date of compliance order #004 to provide the licensee with additional time to achieve sustained compliance.

Issued on this 10th day of July, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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

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

Amended Public Copy/Copie modifiée du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 10, 2019	2019_768693_0005 (A2)	004151-19	Resident Quality Inspection

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street 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

Amended by RYAN GOODMURPHY (638) - (A2)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 4, 2019 to March 8, 2019, March 11, 2019 to March 15, 2019, and March 18, 2019 to March 20, 2019.

The following additional intakes were inspected upon during this Resident

Quality Inspection:

- One Complaint, regarding improper/incompetent treatment of a resident;

- Two Critical Incident Systems (CIS), regarding staff to resident abuse and neglect,

- One Critical Incident System (CIS), regarding a significant change in status of a resident, and;

- One Critical Incident (CIS), regarding resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Best Practice Registered Nurse (Best Practice RN), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Food Service Supervisor (FSS), Environmental Services Supervisor (ESS), Registered Dieticians (RD), Physiotherapists (PT), Occupational Therapists (OT), Resident Counselor, Dietary Aides (DAs), Housekeeping Aides, Coordinator Client Safety & Risk, Lead Hand of Maintenance, Project Manager, Nurse Practitioners (NP) or Registered Nurses in the Extended Class (RN (EC), Pharmacists, Medical Doctors (MD), Resident Assessment Instrument (RAI) Coordinator, Pot Washers, Substitute Decision Makers (SDM), residents and their family members.

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, home's internal investigation notes and complaints, staff education records, as well as reviewed numerous licensee policies, procedure and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **26 WN(s)**
- **13 VPC(s)**
- **8 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

a) A Critical Incident System (CIS) report was submitted to the Director on an identified date, where it was alleged that PSW #104 was negligent towards

residents #001, #002, and #003. It was documented in the report that all three residents were not provided with a specified meal.

Neglect is defined within the Ontario Regulation 79/10, as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Inspector #542 reviewed the home's investigation file, which indicated that PSW #104 was negligent towards residents #001, #002, and #003 by failing to provide them with a specified meal. It was also documented that resident #001 had an identified medical diagnosis and had not received a specified meal or nourishment. Resident #002 was not provided with a specified meal, was left in bed all day and required a certain number of staff for assistance with care, none of which was provided as per their care plan. Resident #003 was not provided with a specific meal or nourishment and did not receive an intervention as per their care plan.

Inspector #542 interviewed the Administrator who indicated that PSW #104 was found to be negligent towards all three residents. The Administrator further indicated that PSW #104 was found to be negligent in a specific month during a specific year, towards two different residents which resulted in a suspension. The Administrator provided two additional CIS reports that were submitted to the Director on a specified date.

Inspector #542 reviewed the two CIS reports that were submitted on a specified date, for neglect. It was documented that resident #018 was provided with care at an identified time and not again until a later identified time. Resident #018 was found to be incontinent, having both their clothing and ambulation device soiled. The second CIS report indicated that resident #019 was not provided with specified care needs. A PSW reported to PSW #104 that resident #019 was incontinent at an approximate time. At a specified time, resident #019 remained to be incontinent, and it was noted that they were not provided with assistance until a later time. PSW #104 was the primary caregiver for resident #018 and #019.

The home completed their investigation which concluded that PSW #104 was negligent towards both residents.

b) A CIS report was submitted to the Director on an identified date, that outlined

alleged neglect. It was documented in the CIS report that resident #006 was not provided with care during a specific shift. Resident #006 was found in the morning, with evidence of care not being provided.

Inspector #542 reviewed the home's investigation file that was provided by the Administrator. It was documented that the incident occurred on a specified date; however, the staff failed to report the incident to anyone until an identified number of days later.

Inspector #542 interviewed the Administrator who acknowledged that the staff did not report the neglect until an identified number of days later.

A review of the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program – RC-02-01- 01" last updated, April 2017, identified neglect as the failure to provide a resident with the treatment, care, services or assistance, required for health, safety or well-being, and included inaction or pattern of inaction that jeopardized the health, safety or well-being of one or more residents. Furthermore, it was documented in the policy that, when any employee or person who became aware of an alleged, suspected or witnessed resident incident of abuse or neglect, they were to immediately report the incident to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at the time. [s. 20. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (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. (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).

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

Findings/Faits saillants :

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

Resident #008 was identified as having a normal functioning bodily process and as needing an assistive device to complete the same bodily process, as per their Resident Assessment Instrument - Minimum Data Set (RAI-MDS) quarterly review, dated with an identified date.

(a) Inspector #625 reviewed resident #008's kardex, from a specified date, located in a specific binder, which identified the resident was on a routine to promote an intervention; and care plan, from a specified date, located in the resident's chart which identified the resident had an assistive device for this intervention and instructions for care for this intervention.

During an interview with PSW #120, they reviewed resident #008's kardex from a binder which listed the resident was on a routine for this intervention, and the care plan from the resident's chart which listed the resident had an assistive device for this intervention. The PSW acknowledged that the plan of care contained different information related to the resident's required specific program care.

During an interview with the Best Practice RN, they stated that the care plan located in resident #008's chart continued to list that the resident used an assistive device, while the kardex in the specified binder identified the resident was on a scheduled routine for this intervention. They acknowledged that resident #008's plan of care was not clear with respect to whether the resident used the specified assistive device or not, and stated that the hard copy care plan in the resident's chart should have been replaced when it was updated.

During an interview with the DOC, they reviewed copies of the kardex from the specified binder and the care plan from the resident's chart and acknowledged that the kardex identified the resident was on a scheduled routine for this intervention and the care plan identified the resident had an assistive device in place for this intervention. The DOC acknowledged that the resident's plan of care did not provide clear direction to staff as to whether the resident still used the assistive device.

(b) Inspector #625 reviewed resident #008's kardex, from a specific date, located in a specified binder, which identified the resident was on a routine for an intervention.

During an interview with PSW #121, they stated the current kardex in the PSW binder was not clear with respect to the specified intervention routine that resident #008 was on. The PSW stated they did not know when the resident needed to complete the intervention as the kardex did not list specific times.

During an interview with the Best Practice RN, they stated that the resident's kardex listed a specified intervention schedule but acknowledged it was unclear to staff as to what the specificschedule was, as specific times the resident was to have completed the intervention were not identified.

During an interview with the DOC, they indicated that resident #008's plan of care did not provide clear direction to staff regarding the resident's specified intervention routine, such as when or how often the resident was to have completed the intervention, and what the routine was. [s. 6. (1) (c)]

2. Resident #011 was observed by Inspector #625, on a specified date, to have been in an ambulation device, positioned in an identified way, with a potential specified restraint in place.

Inspector #693 made further observations of resident #011 on identified dates. During these observations, resident #011 was seen to to have been in an ambulation device, positioned in an identified way, with a potential specified restraint in place. On each occasion, Inspector #693 asked resident #011 to if they were able to release the potential restraint, and the resident was unable to perform the task.

Inspector #693 reviewed the most recent care plan and kardex for resident #011, last updated on an identified date. The care plan identified, under a specified heading, that staff were to monitor resident #011 hourly, when seated in their ambulation device and were to ensure that their identified restraint was fastened at all times when in the ambulation device. The care plan also identified, under another specified heading, that staff were to ensure that resident #011's potential restraint was applied at all times while they were using their ambulation device and that the potential restraint was not a restraint as resident #011 could release it.

During an interview with PSW #106, they stated that if a resident utilized a restraint, it would be identified on the resident's kardex and the care plan. PSW #106 stated that resident #011 utilized a specific restraint when in their ambulation device and that it was considered a restraint as the resident was not able to release it. Together with the Inspector, PSW #106 reviewed resident #011's most recent care plan and kardex, and the PSW identified that the plan of care indicated that the use of the potential restraint for resident #011 was listed as both a restraint and as an aid to daily living. The PSW stated that they were sure that the potential restraint was a restraint, but stated that the plan of care was confusing and unclear as to what the potential restraint was considered. The PSW stated that the plan of care should be simplified to state that the potential restraint was a restraint and what the staff were required to do in terms of the restraint use.

During an Interview with RPN #110 they stated that resident #011 utilized an identified restraint. RPN #110 reviewed resident #011's most recent care plan and kardex and stated that the plan of care was unclear in regards to the use of the identified restraint, as it was listed as both a restraint and as an aid to daily living. The RPN stated that the identified restraint was a restraint and not an aid to daily living, and that the plan of care should be updated to provide staff with clear direction for the use of resident #011's identified restraint.

Inspector #693 obtained a copy of the home's policy, titled," Care Planning, RC-05-01-01", last updated April, 2017. The policy indicated that the care plan, served as a communication tool which enhanced the provision of individualized care. The policy outlined that registered staff and interdisciplinary team members should have ensured that the care plan was revised when appropriate to reflect the resident's current needs.

During an interview with the Administrator, they reviewed resident #011's most recent care plan and kardex, last updated on a specific date, and stated that the identified restraint was listed as both a restraint and as an aid to daily living. The Administrator stated that they were in the process of updating all resident's care plans, and confirmed that resident #011's plan of care did not provide clear directions to staff and others who provided direct care to resident #011.

CO #001 and DR was issued during inspection # 2019_703625_0002 pursuant to the Long-Term Care Homes Act (LTCHA), 2007, s. 6. (1) (c) with a compliance

due date of May 5, 2109. As the compliance date was not yet due at the time of this inspection, this finding will be issued as a WN to further support the order. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

During an interview with the Best Practice RN, they identified to Inspector #625 that resident #011 had a condition that affected specified areas of their body.

Inspector #693 reviewed resident #011's most recent care plan and kardex, last updated on a specific date, and identified that the areas of the specified condition were not identified on the plan of care.

During an interview with PSW #106 they said that if a resident had a specified condition that affected their care in any way, it would be identified in the care plan or kardex. PSW #106 stated that they often provided care for resident #011 and that this resident, had a specific condition that affected identified areas of their body. The PSW stated that sometimes this condition made it difficult for the PSW to complete care and when resident #011 was experiencing this condition they needed more than one staff to complete their care. PSW #106 reviewed resident #011's plan of care, and stated that the specified condition was not listed on their care plan or kardex.

During an interview with RPN #110 and RPN #113 they stated that if a resident had a specified condition it would be identified in their care plan. RPN #110 stated that resident #011 had an identified condition in specific areas of their body that limited the ability of these areas of the body. RPN #110 stated that at times when resident #011 experienced this condition more, they would refuse their medications. RPN #113 stated that if the specific condition was influencing care in any way it should be identified in the care plan. Both RPNs reviewed resident #011's most recent care plan and kardex and stated that resident #011's specified condition was not listed in either document and they should have been.

Inspector #693 obtained a copy of the home's policy, titled,"Care Planning, RC-05 -01-01", last updated April 2017. The policy indicated that the care plan, served as a communication tool which enhanced the provision of individualized care, and

that a care plan was a guide that directed care that was provided to the resident.

During an interview with the Administrator, they stated that the purpose of a care plan was to help guide staff who provided care for residents based on a resident's individual needs or preferences. The Administrator, acknowledged that resident #011's specified condition was not identified on their care plan or kardex. [s. 6. (2)]

4. During an interview with the Best Practice RN, on a specific date, they identified to Inspector #625 that Resident #012 had an identified condition that affected a specified area of their body.

Inspector #693 reviewed resident #012's most recent care plan and kardex, last updated on a specific date, and identified that the areas of the specified condition were not identified on the plan of care or kardex.

During an interview with PSW #114, they stated that they knew the care a resident required and what their individual needs were from reading the kardex and care plan, that were available to them. PSW #114 stated that resident #012 did not have the specific condition identified on their care plan or kardex. The PSW stated that it was their opinion that resident #012 was at the beginning stages of the specific condition in an identified area of their body, but did not completely have this specific condition, and this may be why the specific condition was not identified on resident #012's current care plan or kardex.

Inspector #693 reviewed progress notes electronically for resident #012, and identified an e-note from an identified date, composed by PT #115, that stated they received a referral from a Medical Doctor (MD) to provide a treatment to resident #012 to prevent a a specific condition. The e-note further indicated, that on assessment of resident 012's specified area of their body, the resident was screaming and crying in pain and that PT #115 had identified that resident #012 had the specific condition affecting specified areas of their body.

During an interview with RPN #116, they stated that resident #012 had a specific condition in either one specific area of their body or another specific area of their body, and that resident #012's care plan or kardex should identify and confirm what the specific condition was. RPN #116 reviewed the most recent care plan and kardex for resident #012 and stated that there was no identification of the specific condition on the care plan or kardex and it should have been.

Later in the day, RPN #116 and PSW #114 approached Inspector #693 and explained that they had looked through resident #012's most recent care plan and kardex, as well as their entire medical record and could not determine if resident #012 had the specific condition. Both staff members stated that maybe resident #012 did not have the specific condition and if this was the case, this would explain why the specific condition was not identified on resident #012's care plan or kardex. Together with the Inspector, RPN #116 and PSW #114 reviewed the e-note composed by PT #115 where it was identified that resident #012 had the specific condition that affected an area of their body. RPN #116 stated that resident #012 did not have the specific condition in one area of their body, but maybe they did in another area of their body.

Inspector #693 and RPN #116 observed resident #012 in their ambulation device in their room, with ares of their body in a specified position and manner. RPN #116 asked resident #012 if they were able to utilize a specified area of their body in an identified way, the resident stated that they could not. RPN #116 asked resident #012 if they could try positioning a specific area of the resident's body for them, resident #012 agreed. RPN #116 attempted to position identified areas of the resident's body and the resident cried in pain and their identified area of their body could not be utilized the way in which RPN #116 had attempted. RPN #116 stated that resident #012 did have a specific condition, that affected specific areas of their body, and this should have been identified for staff who provide care, on the care plan and kardex.

During an interview with the Administrator, they stated that the purpose of a care plan was to help guide staff who provided care for residents based on a resident's individual needs or preferences. The Administrator, acknowledged that resident #012's specified condition was not identified on their care plan or kardex. [s. 6. (2)]

5. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

During observations of resident #008, Inspector #625 noted areas of altered skin integrity on identified areas of the resident's body. During a subsequent observation, the Inspector noted areas of altered skin integrity on further identified

areas of the resident's body.

A review of the policy in use in the home, titled, “Extendicare - "Skin and Wound Program: Prevention of Skin Breakdown - RC-23-01-01", last updated February 2017, identified that daily, on all shifts, care staff were to promptly report verbally any changes such as bruising to the nurse.

Inspector #625 reviewed resident #008’s health care record and identified:
- a progress notes with a specified date, by RN #122, which identified the resident had a areas of altered skin integrity on several specified areas of the resident's body;
- a progress note with a specified date, by RN #123, which identified some areas of altered skin integrity to an identified area of the resident's body;
- an Admission Health Examination with a specified date, completed by MD #124, which did not identify that the resident had any areas of altered skin integrity;
- St. Joseph's Care Group (SJCG) Head to Toe Assessments with two specified dates, both of which did not indicate the resident had areas of altered skin integrity present;
- SJCG Head to Toe Assessments with two specified dates, which identified the resident had a specific sized area of altered skin integrity on an identified area of their body, and areas of altered skin integrity on another identified area of their body, and areas of altered skin integrity on other identified areas of their body; and
- a Point of Care (POC) Flow Sheet from a specified month in an identified year, which indicated the resident had areas of altered skin integrity present on identified dates.
The Inspector was not able to locate any other component of the resident's health care record that identified that the resident was susceptible to areas of altered skin integrity, the location of the resident's current areas of altered skin integrity or that the MD or RN (EC) were aware of the resident's areas of altered skin integrity.

During interviews with resident #008, they stated that they could not identify any incidents or events that had caused areas of altered skin integrity on their body and stated they sustained areas of altered skin integrity from treatments they received. The resident identified that areas of altered skin integrity had occurred and that they had affected a large portion of identified areas of their body. The resident showed the Inspector areas of altered skin integrity on several identified areas of their body.

During an interview with PSW #120, they stated that the resident had areas of altered skin integrity present since their admission, and currently had areas of altered skin integrity on several identified areas of their body; "lots of places". The PSW also stated that the resident had areas of altered skin integrity "everywhere" on their body and developed further areas of altered skin integrity every day.

During an interview with RPN #125, they stated they had always known the resident was susceptible to areas of altered skin integrity and was aware that the resident had areas of altered skin integrity, on an identified portion of their body, from a treatment they received.

During an interview with RPN #110, they stated that they were aware of resident #008's areas of altered skin integrity when they provided an identified treatment to the resident. The RPN stated the resident may be on other treatments that caused areas of altered skin integrity.

During an interview with RPN #126, they stated that the areas of altered skin integrity should be reported from the PSW to the RPN who should then report it to the MD or RN (EC), if required. The RPN stated it would be required to report an increase in areas of altered skin integrity to the person who prescribed the identified treatment if it was a side effect of the treatment ordered.

During an interview with RN #123, they stated they worked full time in the home and had never been informed that the resident had areas of altered skin integrity that was a concern or that occurred at an increased frequency. The RN stated they were not aware that the MD or RN (EC) had been notified of areas of altered skin integrity, but stated they should have been notified if areas of altered skin integrity were the side effects of prescribed treatment, or was something they were unaware of so they could assess it.

During interviews with the Best Practice RN, they reviewed resident #008's chart and were not able to locate any documentation that indicated the RN (EC) or MD had been informed of the areas of altered skin integrity. The Best Practice RN identified that the resident's Admission Health Examination, from an identified date, completed by MD #124, did not identify any areas of altered skin integrity present on the resident. The Best Practice RN stated that PSWs should tell RPNs if they see areas of altered skin integrity, and RPNs should notify the MD or RN (EC) if the areas of altered skin integrity had increased so they were aware, as it

was expected to tell the prescriber if there was a side effect of treatment, such as areas of altered skin integrity.

During an interview with the DOC, they stated that they suspected resident #008's areas of altered skin integrity were related to the use of specific medication the resident was administered.

During an interview with Pharmacist #127, they stated that they had been aware of some mild areas of altered skin integrity experienced by resident #008 on admission, but were not aware of an increase in areas of altered skin integrity or extensive areas of altered skin integrity. The Pharmacist met with the resident and the Inspector and observed ares of altered skin integrity on multiple specified areas of the resident's body. The Pharmacist stated that they had not been aware that the areas of altered skin integrity of the resident was to that extent, as it had certainly worsened, since they had last looked at the resident, and stated they would speak with the RN (EC) and MD #124 about the resident's areas of altered skin integrity.

In an interview with the Administrator, they reviewed resident #008's completed SJCG Head to Toe Assessments, the Electronic Medical Administration Record (eMAR) for an identified month in a specific year, and the POC Flow Sheet documentation for the same month, that included two entries recording the presence of areas of altered skin integrity. The Administrator stated the MD or RN (EC) should be informed of any side effects of the medication they had ordered. [s. 6. (4) (a)]

6. A written complaint was submitted to the Director regarding resident #017's wound care treatment, weight loss and health decline since admission to the home on an identified date.

During an interview with complainant #200 and Inspector #196, they alleged neglect towards resident #017. They reported that they had been told of an area of altered skin integrity at a specified time; they had not seen the area of altered skin integrity themselves, until such time as the resident had been transferred to another healthcare facility in a specified month of an identified year. They indicated they were shocked that the resident had declined like this, had developed a area of altered skin integrity, and that an identified change had occurred.

a) The health care records for resident #017 were reviewed regarding the area of altered skin integrity.

The licensee policy titled, "Interdisciplinary Wound Care Team Roles - February 2017 - RC-23-01-01-A1", indicated that the nurse "Informs Wound Care Lead, Physician/NP of any new and/or worsening skin breakdown and as needed" and "Monitors all wounds with every dressing change".

The Physician's Orders from MD #128 identified that resident #017's area of altered skin integrity had not been assessed or observed after a specified date, through to the next month, as during those MD visits the resident was up. The Physician's Orders from a specific date, indicated that if staff had concerns about resident #017's area of altered skin integrity they were to email MD #128 a photo to an identified email address that was left in the order, and on another specified date, the orders again indicated to email photos of the areas of altered skin integrity to MD #128.

A specific assessment tool initiated on a specified date, identified the area of altered skin integrity was a certain size which according to the legend indicated specified characteristics. Documented assessments and dressing treatments on multiple specified dates, identified a different sized area of altered skin integrity, which indicated more severe specified characteristics. On another specified date, a portion of the area of altered skin integrity was identified as a specific rating, which indicated other identified characteristics. On further identified dates, the area of altered skin integrity was identified as a different specific rating, which indicated the most severe characteristics.

The measurements of the area of altered skin integrity was documented on the specific wound assessment tool, from an identified date range, were recorded as specific measurements. There were no measurements of the size on two later dates.

On a specified date, the physician's notes as recorded on the Physician Orders sheet, indicated the area of altered skin integrity was, an identified size and characteristic.

During an interview with the Best Practice RN, the progress notes were reviewed with the Inspector. There was no record of any emails with pictures sent to the Physician, despite the area of altered skin integrity having been assessed as

having progressed from a specified characteristic to a more severe characteristic.

During an interview, the DOC reported to the Inspector, that as indicated in the identified assessment tool, a portion of the area of altered skin integrity progressed from a specified characteristic, which indicated a worsening and the physician should have been notified.

b) Inspector #196 reviewed the "Pain Management Toolkit" May 2016, as provided as the licensee's pain management program. The toolkit included the following:
Interprofessional Team Monitoring, Registered Nursing Staff: "Ongoing assessment is done in collaboration with resident/family/SDM and other team members: when a resident exhibits a change in health status or pain is not relieved by initial interventions…for example PSW reports resident's experience of pain…" and "indicates that pain is present through family/staff/volunteer observation".

The "Pain Management Protocol (PSW)" indicated that the PSW staff were to document on flow sheet and in Med e-care…"PSW Reports to the RPN or RN". The "Pain Management Protocol (RN/RPN)" indicated upon "Direct report of resident in pain" then "RPN/RN completes pain assessment and documents".

The health care records for resident #017 were reviewed specific to pain. The care plan in effect, in a specified month read, under an identified focus, with a specified expected outcome of, "[resident #017] will be comfortable at all times" and included the intervention "observe [resident #017] for signs of pain and report to Registered Staff when [resident #017] experiencing pain." The eMAR indicated the resident was started on a prescribed medication at a regular scheduled dose as well as a PRN medication, on an identified date. The PRN administration history identified that a dose of a prescribed medication, was last given on an identified date, for an unknown reason. No further PRN medication was documented as provided after this date through to a later date. The progress notes were reviewed for a specific time, and there was no indication recorded of resident pain.

During an interview, PSW #129 reported to Inspector #196 that they recalled having provided care to resident #017. In regard to discomfort, PSW #129 stated that this resident would act in a specified manner, when they were repositioned in

bed and they were in pain sometimes when turned in bed. PSW #129 was identified as #3 staff on the POC records for a specified month, and reported that if pain was observed during care then they would check pain for that resident on that shift in POC.

During interviews with PSW #129 and PSW #114, they demonstrated to the Inspector, the POC charting for pain experienced by a resident. There was an area to check off titled, "complained or shows evidence of pain"; an area to record either verbal or observed complaints of pain and had check marks to indicate these complaints; and check mark area which read, "any pain symptoms should be reported to registered staff and documented". Both PSWs #129 and #114 reported that they would mark this off every shift, if a resident had pain, pain daily, and if the resident had reported either verbally or was observed to have pain and if reported to the nurse.

During an interview with the Best Practice RN, they reviewed resident #017's Flow Sheets from a specified month, in POC. The Flow Sheets from a specific time period, indicated that resident #017 was documented as having indicated pain symptoms less than daily on an identified number of shifts; physical signs of pain observed on another identified number of shifts; verbal complaints of pain on another identified number of shifts; and it was also documented on an identified number of shifts: "Any pain symptoms should be reported to registered staff and documented"

The Best Practice RN confirmed to the Inspector, that the most recent quarterly pain assessment was done on an identified date, which indicated daily moderate acute pain; source was muscle; and joint or soft tissues. The Best Practice RN further reported, there were no additional pain assessments completed after this date.

During an interview with the DOC, when questioned where the PSWs would record resident "pain symptoms", they reported it would be on the POC flow sheets. They further reported that there would be documentation in the eNotes and pain assessments that would reflect the communication of resident pain by the PSWs to the registered staff. The DOC reported to the Inspector, that they would expect some record of the communication of pain to the registered staff with regard to the POC documentation of pain from a specified period, for resident #017. The DOC then confirmed the PSW documentation of observed resident pain in an identified month, had increased since the last pain assessment done on

an identified date, as this pain assessment noted the resident was comfortable with the current pain control. [s. 6. (4) (a)]

7. The licensee has failed to ensure the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Inspector #625 observed a specified texture meal items in front of resident #023 during dining room meal observations on specific dates.

During interviews with Inspector #625 on specific dates, resident #023 stated they had been provided with a specific texture diet, but they had a recent swallowing assessment where they thought they had done well and were assessed to have a different specific texture diet. The resident stated they did not want the specific texture meal, they had been given, and did not ask for one.

A review of resident #023's health care record included the Order Sheet and Progress Notes which included a Speech Pathologist recommendation dated a specified date, that recommended a trial to upgrade the resident's diet to a specific texture diet. The next entry, dated a later date, written by the RN (EC) ordered staff to implement the Speech Language Pathologist (SLP) recommendations [including the specific diet texture].

The Inspector also reviewed the RD hours worked and noted RD #108 had worked in the home on an identified date, for 3.5 hours. The Inspector was not able to locate an order for a specific diet, or to implement the SLP's recommendation for a different specific diet texture, written by the RD in the resident's chart that addressed the identified date, recommendation.

During an interview with the FSS, they stated that SLP recommendations were not ordered for residents until the RD signed off on the recommendations and ordered them. The FSS stated that, although resident #023 had been provided the recommendation for a specified texture by the SLP, the FSS did not update the Resident Diet Census until an identified date, after the order to implement the diet texture change had been obtained. The FSS stated that, the home had historically waited for the RD to attend the home on Mondays or Tuesdays to implement SLP recommendations, but the home would be looking to another process so that [nursing] staff processing the recommendations could contact the

Physician or Nurse Practitioner for the order. [s. 6. (4) (b)]

8. 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 written complaint was submitted to the Director regarding resident #017's wound care treatment, weight loss and health decline since admission to the home on an identified date.

Refer to WN #2, finding #6 for further details.

The licensee's skin and wound program titled, "Wound Care Management: Wound Care Management – February 2017 – RC-23-01-02", read, "Document resident/POA/SDM/family communication in the interdisciplinary progress notes including: a. Involvement in the development and awareness of plan of care related to skin/wound;…" The licensee policy, titled, "Skin and Wound Program: Wound Care Management - February 2017 - RC-23-01-01, read "Discuss treatment options with resident/SDM and communicate progress as appropriate".

The health care records for resident #017, specific to an area of altered skin integrity, were reviewed by the Inspector and the Best Practice RN.

The Physician's Orders dated, an identified date, written by MD #128, identified that multiple areas of altered skin integrity were assessed; a specific treatment, and identified therapy was prescribed. A note written by MD #128, identified that an area of altered skin integrity was a certain characteristic related to a specified condition, and other specified characteristics. A check mark was noted beside the order to indicate the SDM was notified. There were no corresponding progress notes documented by the registered staff to indicate the communication with the SDM regarding the information as written in the Physician's Orders.

The Physician's Orders dated, a specified date, identified an assessment of multiple areas of altered skin integrity and specific treatment and additional interventions. A note written by MD #128 identified, an area of altered skin integrity had a certain characteristic, a condition of the area of altered skin integrity had resolved, and on an identified treatment, as well, that the area was another specified characteristic, there was a concern for a more severe

characteristic, and that the treatment intervention was soiled. A check mark was noted beside the order to indicate the SDM was notified. There was a corresponding progress note which indicated that a message had been left for the SDM. There was no information documented in the progress notes by the registered staff to confirm that the SDM had been informed of further assessment of the area of altered skin integrity.

The Physician's Orders dated, an identified date, written by MD #128, identified an assessment of the areas of altered skin integrity and specific treatment, to continue an identified therapy and additional interventions. A note written by MD #128, identified that an intervention was pending, an area of altered skin integrity was now a certain measurement, another area of altered skin integrity had benefited from an identified intervention, a specific measurement and characteristic, not having indicated another identified condition. The specified plan was to continue with an intervention. There was no check mark noted beside the order to indicate the SDM was notified, and no corresponding progress notes by the registered staff to indicate the SDM had been informed of further assessment of the area of altered skin integrity.

According to the Best Practice RN, the best practice was for registered staff to document a progress note regarding the notification of the SDM, and also a check mark on the MD order form that the SDM was notified.

During an interview, the DOC together with the Inspector, reported that the SDM should have been notified of the characteristic or condition of the area of altered skin integrity in a specified month. [s. 6. (5)]

9. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #625 observed specific texture meal items in front of resident #023 during dining room observations on identified dates.

During interviews with Inspector #625, on identified dates, resident #023 stated they had been provided with a specific diet when they had been assessed as able to have a different specific diet. The resident stated they did not want this specific texture meal and did not ask for it.

A review of resident #023's health care record included a SLP recommendation,

dated, an identified date, that recommended a trial to upgrade the resident's diet to a specific texture diet. The next entry, dated another identified date, and written by the RN (EC) ordered staff to implement the Speech Pathologist recommendations.

Inspector #625 reviewed the Resident Diet Census dated, an identified date, which identified resident #023 was ordered a specific texture diet.

During an interview with PSW #106, they stated that staff were required to ask for resident meals by name and a mistake had been made when the resident was provided with a specific texture meal on an identified date. The PSW stated, resident #023 should have been provided with a different specific diet texture.

During an interview with the FSS, they stated that they had updated the Resident Diet Census sheet on an identified date, to include the SLP diet recommendations [including a specific texture diet]. [s. 6. (7)]

10. On an identified date, resident #013 was observed with a specific beverage on the table in front of them. During the observations, PSW #131 reported that the resident had a specific texture beverage and demonstrated the texture as the beverage dripped off of the spoon.

The Inspector along with PSW #131, reviewed the servery list dated, a specific date, which indicated "a specific texture of fluids were to be provided to resident #013. PSW #131 then reported that they had provided a specific texture beverage to resident #013 and upon reading the servery list, confirmed that the incorrect texture of beverage had been provided to the resident. DA #132 proceeded to spoon the accurate specific texture beverage for resident #013.

The health care records for resident #013 were reviewed. The most recent Physician Orders identified an ordered, specific beverage texture and identified medical condition. The current care plan indicated under an identified focus, a specific beverage texture, and under other identified foci noted a different specific beverage texture.

During an interview with the DOC, together with Inspector #196 they reviewed the current care plan for resident #013. The DOC confirmed that care was not provided to the resident as specified and that in two areas of the care plan, different specific texture beverages were listed. [s. 6. (7)]

11. On identified dates, Inspector #196 observed an intervention in place on resident #010's bed.

The health care records of resident #010 were reviewed. The current care plan indicated the resident was a specific level with transferring and bed mobility. The most recent quarterly MDS assessment did not indicate the use of the observed intervention on their bed, and the, "Bed Safety Analysis" dated, an identified date, identified no risk, no specific intervention, and that the resident was a specific level with bed mobility.

During an interview with resident #010, when questioned by the Inspector whether they used the identified intervention on their bed, they reported they did not use the intervention and "they just have them like that".

During an interview with RPN #119, they confirmed to the Inspector, that the identified intervention was in place, on resident #010's bed. The RPN further reported, after a review of the "Bed Rail Safety Analysis", that the intervention should not have been used according to the analysis.

During interviews with the Administrator, they stated that the beds came with the identified intervention, the intervention could be lowered and not used. The Administrator confirmed that the identified intervention was not to be used, as per the analysis. [s. 6. (7)]

12. A written complaint was submitted to the Director regarding resident #017's wound care treatment, weight loss and health decline since admission to the home on an identified date.

Refer to WN #2, finding #6 for further details.

The licensee's skin and wound program titled "Wound Care Management – February 2017 – RC-23-01-02", read, "Document all skin breakdown in the interdisciplinary progress notes (or wound progress note) and in surveillance tools".

The health care records for resident #017 were reviewed for information regarding the provision of an area of altered skin integrity. The care plan included an intervention ordered by an MD for the area of altered skin integrity. A "Wound

Assessment Tool" was initiated on an identified date, for an area of altered skin integrity. The Physician's Orders dated, an identified date, indicated an intervention to be completed. The "Wound Assessment Tool" for an identified month, did not have documented specific interventions and treatments on multiple specified dates.

During an interview with the Best Practice RN, they reported to the Inspector that the registered staff would fill out the "Wound Assessment Tool" every time the treatment was completed. They further reported this tool also served as the weekly wound assessment.

During an interview with the DOC, they confirmed to the Inspector, upon review of the "Wound Assessment Tool", that the physician ordered treatments were not documented as completed on numerous identified dates. They further reported if the treatment was "not charted, it was not done". [s. 6. (7)]

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

Refer to WN #2, finding #6 for further details.

On an identified date, RD #108 conducted a specified assessment on resident #017, based upon a referral by the DOC regarding identified supplements.

The health care records for resident #017 were reviewed. The RD orders on a specified date, indicated the initiation of an intervention, at specific times. The progress notes written by the RD on this same date identified the initiation of the specific intervention to supplement intake of meals and to provide an additional amount of calories/day and a specific amount of protein/day to support wound healing and weight maintenance. The eMAR identified that the intervention was initiated at a specified time on an identified date through to a specified time on another identified date. The dietary flow sheets for an identified month, indicated the provision of the intervention in specific amounts, on identified dates at specified meals.

During an interview with the Best Practice RN, they reported to the Inspector that a new direction had been implemented on an identified date, that changed the process for staff to follow with regard to a specific intervention. Specifically, the RPNs were no longer to provide or sign for the intervention, as this was now a

PSW task.

Together with the Inspector, the Best Practice RN reviewed the dietary flow sheet for the time period after an identified date, and confirmed the intervention was not recorded as provided to resident #017 as had been ordered. [s. 6. (9) 1.]

14. Resident #012 was determined to require further inspection related to specific nutritional characteristics.

Inspector #693 reviewed resident #012's most recent care plan, last updated on an identified date. The care plan identified that resident #012 was to receive an identified nutritional intervention, at specified times.

Inspector #693 reviewed the "orders" section of resident #012's medical record and identified an order form an identified date, composed by RD #108, which stated for a specific nutritional intervention to be administered at specified times.

During an Interview with RPN #116, they stated that it was the responsibility of the PSWs to administer the identified nutritional intervention to residents and that they document the amount that the Resident had received in Point of Care (POC).

Inspector #693 reviewed the POC documentation, titled, "Dietary Report" for resident #012, from a specified time period. The report identified an item at a specified meal with an identified title, and multiple items at specified meals with identified titles. The report did not indicate what the item was. The report indicated that if a resident refused the intervention, "R" would be documented, if a resident was sleeping "S" would be documented, and if a resident was away "L" would be documented. The report did not have anything documented with regards to the provision of the intervention on an identified number of days at specified meals. The report was reviewed for a specific time period, and it was identified that on a specified number of shifts, the documentation for resident #012's intervention was not completed.

During an interview with PSW #114, they stated that resident #012 received a nutritional intervention at specified times. PSW #114 stated that it was the PSWs' responsibility to administer the intervention to resident #012 and to document in POC the amount of the intervention that the resident had consumed. The PSW stated that there was special coding within the POC to document if the resident refused, was asleep or away from the home. Together with the Inspector, PSW

#114 reviewed the Dietary Report for resident #012 from a specified time period, and stated that the identified item represented the intervention, and they did not know what the other item represented, but speculated that maybe other staff chart this if the resident did not receive the intervention in entirety. PSW #114 stated that the identified item was documented several times and they did not know what this meant. The PSW confirmed that a blank space on the Dietary Report would indicate that the intervention for resident #012 was not documented and this would also mean that the intervention was not given on any of the days and meals identified as having a blank space.

Inspector #693 obtained a copy of the home's policy, titled, "RC-18-01-04 Snack/Nourishment", last updated, February 2017. The policy indicated that ordered interventions were to be offered and available at each indicated time, and that staff were to have documented the intake of the interventions. The policy also indicated that any refusal of interventions was to be documented.

During an interview with the Administrator, they stated that if the RD ordered an intervention for a resident, the PSWs were responsible for delivering this to the resident as well as for documenting in POC; including the amount. The Administrator reviewed the Dietary Report for resident #012, for an identified time period. The Administrator acknowledged that the documentation did not include the name of the intervention but rather stated the generic terms for the identified items. They stated that this generic terminology was because all identified items in the home were displayed for all residents and this generic wording seemed to have simplified things for the staff. The Administrator, stated that for resident #012 the generic terms represented if they received a specific amount of the ordered intervention. The administrator confirmed that the blank spaces on the Dietary Report indicated that staff had not documented the provision of the intervention for resident #012.

CO #002 and DR was issued during inspection #2019_703625_0002 pursuant to the Long-Term Care Homes Act (LTCHA), 2007, s. 6. (9) 1. with a compliance due date of May 5, 2109. As the compliance date was not yet due at the time of this inspection, this finding will be issued as a WN to further support the order. [s. 6. (9) 1.]

15. 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 the resident's care needs changed or care set out in the plan was no longer necessary.

During a staff interview, it was identified that resident #008 sustained a specified incident within the previous 30 days.

Inspector #625 reviewed resident #008's current kardex and care plan, dated, a specified date, which identified the resident had an intervention that was to be worn while in their wheelchair and while they were in bed, as a falls prevention and management intervention.

During multiple observations of resident #008, Inspector #625 did not observe the identified intervention to be in place on either the resident's wheelchair or their bed.

During interviews with resident #008, they stated that they no longer had the identified intervention and had not had one since before they last sustained a specific incident. The resident stated that staff had removed the intervention because the resident no longer needed it.

During an interview with PSW #120, they acknowledged that resident #008's current care plan and kardex listed the identified intervention. The PSW stated the resident did not utilize the intervention and it had been removed for over one month because the resident knew how to take the intervention off so that it would not function properly, making it pointless to have the intervention.

During interviews with PSW #133 and RPN #134, they attended resident #008's room and confirmed that the resident did not have the identified intervention on their wheelchair or bed. The staff confirmed the resident's kardex and care plan identified the intervention was required and stated they did not know why the resident did not have the intervention in place.

During an interview with RPN #125, they confirmed that the resident's kardex and care plan both listed that the intervention was required. The RPN stated they did not know why the intervention was not in place and, according to the plan of care; the resident was supposed to have one. The RPN checked electronic progress notes and orders in the resident's chart and could not find documentation to indicate that the intervention had been removed. The RPN stated that a registered staff member must have removed the intervention for a reason, which they should

have documented and updated the care plan.

During interviews with the DOC, they confirmed the resident's current care plan and kardex both identified the resident used the identified intervention, that the intervention was not in place, and that the resident's health care record did not identify when or why it had been removed. The DOC stated that they had spoken with staff and determined that the intervention had been removed as it was no longer required by the resident. The DOC acknowledged that the resident's plan of care had not been revised to reflect the resident's current needs as the intervention was no longer required by the resident but continued to be listed in the plan of care. [s. 6. (10) (b)]

16. During a staff interview, with the Best Practice RN, it was identified that resident #012 had experienced an incident on an identified date, where they fell from their bed onto a falls mat, and did not sustain an injury.

Inspector #693 reviewed resident #012's most recent care plan and kardex, last updated on an identified date. The plan of care indicated that resident #012 utilized an identified intervention, at all times they were seated in their chair. The plan indicated that the intervention was located in a specific area.

Inspector #693 observed resident #012 on an identified date, in their ambulation device, with the identified intervention in place in a manner different than what the care plan indicated.

During an interview with PSW #117, they stated that if a resident had specific falls prevention interventions, they would be listed on their kardex and care plan, PSW #117 stated that resident #012 was a specified level of risk and used an identified intervention, while they utilized their ambulation device. PSW #117 and Inspector #693 observed resident #012 seated in their ambulation device with an identified intervention in place. PSW #117 stated that resident #012, previously used the identified intervention that was operated in a specified manner, but that there was a problem with the battery or some other kind of problem that they could not remember, in an identified month or another identified month, and so the identified intervention was utilized in a different operational manner instead. Inspector #693 and PSW #117 reviewed resident #012's most current care plan and kardex, and PSW #117 stated that the plan of care needed to be updated to indicate the use of the identified intervention in the correct operation.

Inspector #693 reviewed the progress notes, electronically for resident #012. An e-note dated, a specified date, composed by PT #115, identified that resident #012 utilized an identified intervention that was operated in a specified way. In an e-note, dated, a later specified date, composed by RPN #118, they identified that resident #012 utilized an identified intervention in another manner.

Inspector #693 obtained a copy of the home's policy, titled, "Care Planning, RC-05-01-01", last updated April 2017. The policy indicated that the resident plan of care, which included the care plan, served as a communication tool which enhanced the provision of individualized care, and that as the resident's status changed, members of the interdisciplinary team were to update the plan of care so that at any point in time, the care plan would be reflective of the current needs and preferences of the resident. The policy also indicated that, staff were to ensure that the care plan was revised when appropriate to reflect the resident's current needs.

Together, with the Inspector, the Administrator observed resident #012 in their ambulation device. The Administrator confirmed that resident #012 had an identified intervention in place that was of a certain type and not of the type that was listed on the resident's care plan. The Administrator stated that resident #012's plan of care needed to be updated to include the use of the identified intervention of a certain type, and remove the identified intervention of another type. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident; that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Ontario Regulation 79/10, s. 1, defines "topical" to mean a drug in the form of a liquid, cream, gel, lotion, ointment, spray or powder that is applied to an area of the skin and is intended to affect only the local area to which it is applied.

On an identified date, Inspector #625 observed a specified topical medication, in its original box which displayed resident #026's surname written in black ink, located in the shared resident washroom for an identified room.

On an identified date, the Inspector observed an unlabelled specified topical medication located in the shared resident washroom for an identified room.

On an identified date, the Inspector again observed the specified topical medications, in the shared washrooms of identified rooms.

The Inspector reviewed an order for an identified topical medication, dated, a specific date, for resident #008, who resided in an identified room, and an order for another identified topical medication, dated, a specific date, for resident #026, who resided in an identified room.

During an interview with the the Best Practice RN, they reviewed residents #008 and #026's charts and acknowledged the orders, as reviewed by the Inspector. The Best Practice RN then attended the shared washrooms for the identified rooms, and observed the identified topical medications to be unsecured, as previously identified by the Inspector. The Best Practice RN stated that the topical drugs should not have been kept in the unsecured shared resident bathrooms which were accessible to anyone.

During an interview with the DOC, they acknowledged that topical drugs, including the specified medications, should have been kept in an area where they were secured and locked, as per legislative requirements. [s. 129. (1) (a) (ii)]

2. During observations of resident #011 on an identified date, Inspector #196 noted an identified number of prescription labelled topical medication on the bedside table.

During an interview with PSW #135, they reported that the identified topical medication should not have been kept on the bedside table.

During an interview with PSW #114, they reported that prescription medications were to be stored in the locked resident carts.

A review of the pharmacy provider's (Janzen's) policy re: "Medication Storage in the Facility", revised September 2018, indicated, "Medications are stored safely,

securely, and properly, following manufacturer's recommendations or those of the supplier, and in accordance with federal and provincial laws and regulations. The medication supply is accessible only to authorized personnel."

During an interview with the DOC, they reported that topical prescription medications, creams, were to be kept and stored securely, locked in resident care cart or in medication room, or in the medication cart and were not to be kept at a resident's bedside. [s. 129. (1) (a) (ii)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

practices, to minimize risk to the resident.

During resident observations, Inspector #625 observed an intervention in place on resident #008's bed.

During interviews with Inspector #625, PSWs #120, #133 and #136, stated that resident #008 used the identified intervention when in bed; this was also confirmed by resident #008.

On August 21, 2012, a notice was issued to the Long Term Care Home (LTC) Administrators from the Director of the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, identifying a document produced by Health Canada entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was expected to be used as the best practice document in LTC Homes and provides clear procedures and dimensional criteria with respect to evaluating bed systems using a cone and cylinder tool. The Health Canada Guidance (HCG) document also includes the title of a companion guide developed by the Food and Drug Administration (FDA) in the United States entitled "Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006". The guide includes information with respect to the various options and corrective strategies available to mitigate entrapment zones, a guide to buying beds, how to inventory bed systems and reviews the dimensional criteria of bed systems. The documents are considered prevailing practices, which are predominant, generally accepted widespread practice as the basis for clinical decisions with respect to bed safety.

The home's policy titled, "BED SAFETY – PREVENTION OF ENTRAPMENT – LTC 5-80", approved June 2016, identified that each resident and his/her bed must have been assessed individually for entrapment risks, and interventions intended to reduce the risk of entrapment should have been tailored to meet each individual's needs. The policy identified that all residents should have an individualized Bed Safety Analysis completed. The policy also identified that a second document, a Bed Rail Safety Analysis, was to be completed on admission; whenever a Bed Safety Analysis was performed; whenever a resident changed his/her mattress, bed fame, or any other bed-related products; and whenever a staff member felt it was necessary for resident safety.

Resident #008's MED e-care information identified that the resident was admitted

to the home on an identified date, into a specified room, and then transferred to a different room on an identified date.

Inspector #625 reviewed documents titled Bed Safety Analysis and Bed Rail Safety Analysis, both dated an identified date, and both of which identified that the bed used by resident #008 in room an identified room had no entrapment zones failed.

During an interview with the Best Practice RN, they stated that they had completed both the Bed Safety Analysis and Bed Rails Safety Analysis documents dated an identified date, for resident #008 when they had resided in an identified room. The Best Practice RN indicated that they did not know which type of bed or which specific bed they had assessed, or if the resident was still using the same bed or not. The Best Practice RN stated their notation that there had been no entrapment zones failures was based on their visual estimation if a hand or leg could get wedged in the different areas of the bed. The Best Practice RN indicated that they had not received any special training on assessment of the bed systems or entrapment zones.

During an interview with the Coordinator Client Safety & Risk, they stated that they had completed entrapment zone testing with OT #138 in the past but, more recently, had conducted a visual inspection [which did not include testing of entrapment zones] of bed systems, in January 2018. The Coordinator referred to a table provided to the Inspector titled, "Bethammi Nursing Home Assessment of Beds – January 2018". The Coordinator stated they had not retained original testing documents used to record the results of the earlier entrapment zone testing completed with the bed system measurement device.

Inspector #625 reviewed the table titled, "Bethammi Nursing Home Assessment of Beds – January 2018", and noted the concerns recorded included:
- the footboard for one bed appeared to be a headboard installed on an angle;
- mattress keepers were not engaged on multiple beds;
- mattresses were sitting outside of mattress keepers on multiple beds;
- mattress keepers were missing;
- mattresses were too short for multiple beds;
- long comforters tucked under mattresses elevated the mattress out of the keepers on multiple beds;
- fitted sheets were too tight for multiple mattresses causing them to curl up and shorten;

- mattresses were reversed on multiple beds;
- multiple mattresses required replacement as they were in poor condition;
- a low air loss mattress was not securely attached to a bed; and
- one bed was mislabelled as a Stryker FL 13 when it was a Joerns Hi-Low bed.

The table also identified that Bed Safety Analysis documents could not be located for 13 bed systems, one did not contain the year the assessment was completed and another was undated and unsigned. The table also identified that one of the mattresses could not be visually assessed as the resident was sleeping at the time.

The table identified that full bed rails were used for five residents, and that, for all five of those bed systems, Bed Safety Analysis documents should have been repeated due to discrepancies between the use of full rails and those listed on the most recent Bed Safety Analysis; the reasons for full rail use was not clearly documented; entrapment prevention equipment was needed if residents were considered at risk for entrapment; a bed system using a low air loss mattress and full rails had no Bed Safety Analysis located on the chart.

The table also identified numerous Bed Safety Analysis that were incomplete, not dated, contained information that was different than that observed. In total, the table recommended the home complete 13 Bed Safety Analysis documents; repeat 26 Bed Safety Analysis documents, and repeat an additional 12 Bed Safety Analysis documents, if criteria had changed.

Furthermore, one entry identified the Bed Safety Analysis had been completed in January 2018, but that the mattress had since changed and the completion of the analysis should have been repeated. A second entry identified the Bed Safety Analysis had been completed on January 27, 2018, and the overlay had been completely deflated and the mattress was cracked and required replacement. Despite the Bed Safety Analysis documents being completed either the same month, or the previous month, neither had reflected accurate or current analysis for the residents' bed systems.

The Inspector noted that two of the entries, identified the bed type as Invacare CS7, with a mattress type of GeoMatt 80", and full bed rails. One had a Bed Safety Analysis dated, November 17, 2017, that identified the resident used two bed rails, not full bed rails; and another dated December 12, 2017, identified that entrapment prevention equipment may be required and the Bed Safety Analysis

(completed the previous month) should have been repeated.

A review of a document titled, "CS7 bed assessment – 80" Geo Matt with full rail", dated February 2, 2017, and provided by the home identified that entrapment zones 4 and 6 were a risk at the head of the bed with the full bed rails in use. The document recommended eliminating the use of full rails.

During an interview with the Project Manager, they stated that the home had ordered 22 new beds in October of 2018, and that none of the 22 beds had been tested for bed entrapment.

During interviews with the Administrator, they stated that nursing staff completed entrapment zone testing although they did not have any specialized training to do so, and did not use a bed system entrapment tool to assess the beds. The Administrator also stated that one prototype bed [of the CS7 bed] had been tested for entrapment zones, not all of the beds in the home. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails were used, other safety issues related to the use of bed rails were addressed, including height and latch reliability.

During resident observations, Inspector #625 observed an intervention in place on resident #008's bed.

A review of resident #008's current care plan effective on an identified date, identified the resident used the observed identified intervention when in bed.

A review of Flow Sheets from a specified time period, identified resident #008 used an intervention on their bed, on multiple day, evening and night shifts.

During interviews with Inspector #625, resident #008 stated that they used an intervention on their bed to assist with bed mobility.

During interviews with PSWs #120, #133, and #136, they stated that resident #008 used an intervention on their bed when in bed.

(a) The licensee's policy titled, "Bed Safety - Prevention of Entrapment - LTC 5-80", approved June 2016, identified that maintenance staff were to perform quarterly bed safety audits to ensure bed rails and all other parts of the bed were

free from defect and were working properly.

During an interview with the Project Manager, they stated that quarterly bed safety audits had not occurred as listed in the home's policy, but annual bed checks were completed by Maintenance. The Project Manager provided Inspector #625 with completed "Bed Safety Checklists – Bethammi Nursing Home for 2018".

Inspector #625 reviewed the Bed Safety Checklists and noted that the checklist did not include assessment of the height of the bed rails. In addition, 51 checklists had been provided while the home had 112 resident beds. The Inspector had not been provided with Bed Safety Checklists for 54 per cent of the beds in the home.

During a subsequent interview with the Project Manager, they acknowledged that only 51 Bed Safety Checklists had been completed in 2018 and that the assessment of bed rail height was not included in the check completed by Maintenance.

During an interview with the Administrator, they reviewed the "Bed Safety Checklists – Bethammi Nursing Home" completed for 2018, and acknowledged that not all 112 resident beds in the home had records of assessment of latch reliability, and that the Bed Safety Checklists did not identify that bed rail height had been assessed.

(b) The licensee's policy titled, "Bed Safety - Prevention of Entrapment - LTC 5-80", approved June 2016, identified the every resident's bed was to be inspected upon admission to the home using the Bed Safety Checklist.

With respect to resident #008, the resident's MED e-care information identified that the resident was admitted to the home on an identified date, into a specified room, and then transferred to another specified room, on an identified date.

A review of "Bed Safety Checklists – Bethammi Nursing" home identified a checklist completed for a "71523 Bertec" bed, located in an identified room, on a specified date, and for an "Intertek 3074940" bed, located in an identified room, on a specified date. The Inspector was not able to locate a Bed Safety Checklist for either bed, in either room, which would have coincided with the resident's transfer and use of a new bed in an identified room or, alternatively, the use of either of the beds by another resident.

During an interview with the Project Manager, they acknowledged that they did not know what location the beds were currently in as they were not aware if staff had moved any resident beds.

During an interview with the Administrator, they were not able to confirm if resident #008 continued to use the same bed when they transferred from an identified room to another identified room. [s. 15. (1) (c)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended: CO# 004

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, other safety issues related to the use of bed rails are addressed, including height and latch reliability, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that, when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Resident #008 was identified as having an identified level of pain as per their Resident Assessment Instrument - Minimum Data Set (RAI-MDS) quarterly review dated, an identified date.

Inspector #625 reviewed the home's toolkit titled, "Pain Management Toolkit Long-Term Care Bethammi Nursing Home", dated May 2016, which identified registered nursing staff were to document the effectiveness of the interventions in the eMAR with written follow-up in the e-notes.

A review of the resident's current care plan effective on an specified date, identified the resident had pain in an area of their body and that staff were to administer medications as ordered and assess the effectiveness of the medications given.

A review of analgesic medication ordered for resident #008 identified orders for a specified pro re nata (PRN) medication, and for another specified medication

when required.

Inspector #625 reviewed resident #008's eMAR and noted that the two specified PRN medications had been administered, multiple times in an identified month.

A review of the PRN History report for resident #008 for a specified month, identified that a specific PRN medication was administered an identified number of times for pain, and another PRN medication was administered an identified number of times for pain. The corresponding Follow-Up Notes report identified that 91 per cent, of the first identified PRN pain medication; and 100 per cent, of the second PRN pain medication administration entries did not have corresponding follow-up notes regarding the effectiveness of the medications recorded on the eMAR. A review of the resident's electronic notes identified no documentation of the effectiveness of the identified PRN pain medications administered in a specified month.

A review of the PRN History report for resident #008 for an identified month, identified a specified PRN medication was administered a specified number of times for pain, and another specified PRN medication was administered a specified number of times for pain. The corresponding Follow-Up Notes report identified 100 per cent, of the first specified PRN medication; and 92 per cent, of the second PRN medication administration entries did not have corresponding follow-up notes regarding the effectiveness of the medications recorded on the eMAR. A review of the resident's electronic notes identified no documentation of the effectiveness of the PRN pain medications administered in a specified month, excluding the one note on the effectiveness previously identified in the specified month.

A review of the PRN History report for resident #008 from a specified time period, identified a specified PRN medication was administered a specified number of times for pain, and another specified PRN medication was administered a specified number of times for pain. The corresponding Follow-Up Notes report identified 100 per cent, of the first specified PRN medication; and 100 per cent, of the second PRN medication administration entries did not have corresponding follow-up notes regarding the effectiveness of the medications recorded on the eMAR. A review of the resident's electronic notes identified one entry related to the effectiveness of the second identified PRN medication administered in an identified month.

During an interview with RPN #110, they stated that resident #008 had identified PRN medications ordered for pain and that staff were supposed to document the effectiveness of PRN medications administered.

During an interview with RN #123, they acknowledged multiple missing entries related to the effectiveness of the identified PRN medications administered to resident #008 in the identified months. The stated that staff were required to document the effectiveness of each prn analgesic administered.

During an interview with the RAI Coordinator, they acknowledged that the PRN History report for resident #008, for a specific time period, did not contain documentation of the effectiveness of the identified PRN medications administered; the report for an identified month did not contain documentation of the effectiveness of the first identified PRN medication administered and contained one documented effectiveness entry for the second PRN medication administration which identified the resident slept well; the report for an identified month only had one entry documenting the effectiveness of the first PRN medication administered and did not contain documentation of the effectiveness of the second PRN medication that had been administered. The RAI Coordinator acknowledged that the MED e-care report they had generated identified resident #008 had an identified number of entries where the follow-up effectiveness of prn medications administered, including analgesic medications, since the resident's admission, were not documented in the eMAR follow-up notes. The RAI Coordinator also acknowledged that the MED e-care report they had generated for the entire home for all current residents identified there were 4951 entries (on 496 pages) where the follow-up notes to the effectiveness of administered prn medications, including pain medications, were undocumented on the eMAR notes as required.

During an interview with the Best Practice RN, they acknowledged that there were multiple missing entries in the identified months, on the effectiveness of resident #008's PRN analgesic medications. The Nurse stated that staff were required to document the effectiveness of the prn analgesic medications administered.

During an interview with the Administrator, they reviewed the PRN History and Follow-Up List reports and progress notes for resident #008. They acknowledged multiple missing documentation each month for the administered PRN medications, and identified some months had zero or one follow-up effectiveness documented but should have had multiple entries. The Administrator stated staff

were required to document the effectiveness of PRN analgesic medication. [s. 134. (a)]

2. The most recent MDS assessment identified Resident #013 as having the prevalence of an identified level of pain.

The licensee policy, "Pain Management Toolkit - May 2016", indicated that the registered staff were to, "Document[s] the effectiveness of the interventions in the eMar with written follow up in the eNotes".

A review of the analgesia orders in MED e-care for resident #013, identified an identified scheduled medication and an identified prn medication.

During an interview with RPN #140, they reported to Inspector #196 that a prn dose of an identified medication had been administered. They further reported that there was no record of the effectiveness documented.

During an interview with RPN #126, they reported to the Inspector that registered staff would record the effectiveness of a prn medication in the eMar and the program would prompt the registered staff to enter the effectiveness, approximately one hour after administration.

During an interview with the Inspector, the RAI Coordinator, reviewed the eMar and confirmed that the reason for the prn medication administration on a specific shift on an identified date, for resident #013, was not identified, nor was the effectiveness documented or assessed. They further reported that it was a requirement for the registered staff to record this information.

During an interview with the DOC, they confirmed to the Inspector that registered staff were to document the effectiveness of prn analgesia in the eMar and this was in the policy and staff were to follow the medication policies. [s. 134. (a)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 59. Therapy services
Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and
(b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.

Findings/Faits saillants :

1. The licensee failed to ensure that therapy services for residents of the home were arranged or provided under section 9 of the Act that included, (b) occupational therapy and speech-language therapy.

A written complaint was submitted to the Director regarding resident #017's wound care treatment, weight loss and health decline since admission to the home on an identified date.

Refer to WN #2, finding #6 for further details.

The health care records for resident #107 were reviewed. The Physician's Orders written by MD #128 on an identified date, indicated that a specific intervention was to be put in place with OT consultation, and on another identified date indicated for an OT to assess for another intervention, and both orders indicated a referral was sent. The progress notes did not indicate that an OT consultation had occurred as a result of either referral.

During an interview with OT #141, they reported that they had received referrals to see resident #017 on identified dates, via email. The OT provided copies of the email referrals, and both indicated the referrals were upon the physician's request. The OT further reported that they only had three hours per week in the home and needed to prioritize the referrals and sometimes did not get to see everyone. The OT further reported that the resident was not assessed in relation to these referrals and no action was taken as a result of these referrals.

During an interview with the Administrator, they reported they would expect that the referrals to the OT would have been completed or some sort of communication from the OT that they had not assessed the resident. [s. 59. (b)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: 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 an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home.

(a) During an interview with Inspector #625, the Best Practice RN identified that resident #009 experienced an incident on a specified date, while walking without their ambulation device in an identified area of the home.

A review of the home's policy titled, "Falls Prevention and Management Program – RC-15-01-01", last updated February 2017, identified that, if a resident hit their head or was suspected of hitting their head (such as during an unwitnessed fall), staff were to complete the Clinical Monitoring Record.

A review of resident #009's electronic progress notes included a note from an identified date, which identified the resident had experienced an incident, was found on the floor, had a notable injury on an identified area of their body, and complained of pain.

A review of a Clinical Monitoring Record initiated for resident #009's incident on an identified date, identified that staff were to monitor the resident every hour for four hours followed by every eight hours for 72 hours. The record identified:
- a specified number of the pain assessment monitoring entries were not recorded; a specified number, of the pain assessment entries did not include the date and time of the entry;
- a specified number, of the vital sign monitoring entries were not documented; and
- a specified number, of the neurological vital sign monitoring entries were not documented.
In addition, the Inspector noted that, of the specified number of entries, the first and second monitoring entries were recorded two hours apart, the third and fourth entries were recorded greater than 12 hours apart, and the fourth and fifth entries were recorded greater than 24 hours apart.

During a second interview with the Best Practice RN, they elaborated that resident #009 had sustained an injury on an identified area of their body during the unwitnessed incident on an identified date. The Best Practice RN stated staff had been required to initiate a Clinical Monitoring Record as the incident was unwitnessed and resulted in an injury on a specified area of their body. The Best Practice RN reviewed the Clinical Monitoring Record for resident #009's accidental incident on an identified date, and acknowledged that the record was incomplete.

During an interview with the DOC, they reviewed the Clinical Monitoring Record for resident #009's incident on an identified date, and acknowledged that it was incomplete as multiple monitoring entries had not been recorded.

(b) During observations of resident #009, Inspector #625 noted an area of altered skin integrity on the an area of the resident's body, including a characteristic area of altered skin integrity on an identifies side of the resident's body area; an area of altered skin integrity under and over an area of the resident's body; and an area of altered skin integrity on multiple areas of the resident's body area.

A review of the home's policy titled, "Falls Prevention and Management Program – RC-15-01-01", last updated February 2017, identified that, for 72 hours post-fall staff were to assess falls-related items, including bruising, each shift. The policy also directed staff to document the results of all assessments and actions taken

during the 72-hour post-fall follow-up.

A review of resident #009's electronic progress notes also included a note related to resident's accidental incident, dated an identified date, at a specified time, which identified the resident had an area of altered skin integrity to identified areas of the body. The Inspector was not able to locate any other entries related to the resident's incident or the areas of altered skin integrity they had sustained to their identified area of their body, from the date of the incident to another identified date.

The Inspector noted an undated narrative entry on the resident's Clinical Monitoring Record, captured in the pain assessment area, which identified a characteristic area of altered skin integrity on a portion of the resident's area of their body.

During an interview with the Best Practice RN, they stated that staff should have documented the area of altered skin integrity present on the resident for 72 hours following the incident, as per the home's policy. The RN stated that a minimum of six shifts should have documented the presence of the area of altered skin integrity and acknowledged that the resident continued to have areas of altered skin integrity present from the incident.

During an interview with the DOC, they acknowledged that the home's Falls Prevention and Management Program identified staff were to have assessed characteristics, including identified areas of altered skin integrity, for 72 hours post-fall. The DOC stated that post-fall areas of altered skin integrity should have been recorded in the resident's progress notes each shift for 72 hours after their fall. The DOC reviewed resident #009's progress notes and acknowledged that, after the note detailing the fall, only one subsequent note identified the resident had sustained areas of altered skin integrity. [s. 48. (1) 1.]

2. (a) During an interview with Inspector #625, the Best Practice RN identified that resident #008 sustained an accidental incident within the previous 30 days, on an identified date, while transferring without staff assistance.

A review of resident #008's electronic progress notes included a note dated an identified date, which identified that resident #008 had been calling out for help, a PSW found the resident on the floor and a "HIR [Head Injury Routine was] initiated by RPNs".

A review of a Clinical Monitoring Record initiated for resident #008's incident on an identified date, indicated that staff were to monitor the resident every hour for four hours, followed by every eight hours for 72 hours. The record identified:
- a specified number, of the pain assessment monitoring entries were incomplete;
- a specified number, of the vital sign monitoring entries were incomplete; and
- a specified number, of the neurological vital sign monitoring entries were incomplete.

During an interview with the DOC, they reviewed the Clinical Monitoring Record for resident #008's incident on an identified date, and acknowledged that multiple monitoring entries had not been recorded, and that the record was incomplete as previously identified by the Inspector.

(b) A review of the home's policy titled "Falls Prevention and Management Program – RC-15-01-01", last updated February 2017, identified that, for 72 hours post-fall staff were to assess falls-related items, including pain, bruising, change in functional status, change in cognitive status and changes in range of motion, each shift. The policy also directed staff to document the results of all assessments and actions taken during the 72-hour post-fall follow-up.

A review of resident #008's electronic progress notes included one note related to the resident's incident on an identified date. The note, entered at a specified time, was the initial entry documenting the incident, which the note identified occurred at approximately an identified time. The note identified that the resident had sustained a specified injury to identified areas of their body, complained of pain in an identified area, was exhibiting other identified responses, was difficult to converse with due to being an identified characteristic and was experiencing a medical condition also likely due to the resident being an identified characteristic. The Inspector was not able to locate any other progress notes related to the incident, excluding a note by the home's former RD in response to a dietary referral for the injuries sustained during the incident.

During interviews with the DOC, they acknowledged that the home's Falls Prevention and Management Program required 72 hours of post-fall assessment of pain, bruising, change in functional status, change in cognitive status, changes in range of motion, including documentation of results of all assessments and actions taken during the 72 hour post-fall follow-up. The DOC stated that assessment of some items not listed on the Clinical Monitoring Record should

have been recorded in the resident's progress notes each shift for 72 hours after their fall. The DOC reviewed resident #008's progress notes and acknowledged that only one progress note was documented by nursing staff, the progress note entered for the fall itself. The DOC stated staff should have documented the criteria detailed in the program for 72 hours post-fall.

(c) A review of the home's policy titled "Falls Prevention and Management Program – RC-15-01-01", last updated February 2017, identified that staff were to implement a Post-Fall Assessment Tool, Appendix 11. The Post-Fall Assessment Tool identified that, if the resident had pain, staff were to complete a pain assessment.

The Post-Fall Assessment Tool for resident #008's incident on an identified date,indicated the resident had pain.

Inspector #625 was not able to locate a Pain assessment completed for resident #008's incident on an identified date.

During an interview with the DOC, they acknowledged that the Post-Fall Assessment Tool identified a pain assessment was to be completed if a resident experienced pain, and that resident #008's Post-Fall Assessment Tool dated an identified date, indicated that resident #008 experienced pain. The DOC reviewed completed Pain assessments and confirmed that a Pain assessment had not been completed for the incident that occurred on an identified date, although one was required. [s. 48. (1) 1.]

3. During a staff interview, with the Best Practice RN, it was identified that resident #012 had experienced an accidental incident on an identified date, where they fell from their bed onto a falls mat, and had not sustained an injury.

Inspector #693 reviewed the progress notes, electronically for resident #012. The e-note from an identified date, composed by RPN #119 indicated that resident #012 had experienced an unwitnessed accidental incident and a PSW found resident #012 lying down, on the falls mat beside their bed and resident #012 stated that they slid off their bed onto the floor. The e-note indicated that resident #012 did not exhibit signs of injury.

Inspector #693 reviewed the home's policy, titled, "Fall Prevention and Management Program, RC-15-0101", last updated February 2017. The policy

indicated that that if a resident experienced an unwitnessed fall, staff were to have completed a "Clinical Monitoring Record", "Post-Fall Assessment Tool", a "Scott Fall Risk Screen" as well as a Post-Fall Huddle. The policy also directed staff to assess the following; for 72 hours post fall, at each shift: pain, bruising, change in functional status, change in cognitive status; and changes in range of motion.

A review of a Clinical Monitoring Record initiated for resident #012's incident on an identified date, indicated that staff were to monitor the resident every hour for four hours followed by every eight hours for 72 hours. The record identified:
- a specified number, of the pain assessment monitoring entries were not recorded;
- a specified number, of the vital sign monitoring entries were not documented; and ;
- a specified number, of the neurological vital sign monitoring entries were not documented.
In addition, the Inspector noted that, the first set of vital signs and neuro vital signs were completed at a specified time, and the second set was not completed until a later specified time. The inspector also noted that between the fourth and fifth entries there was a five hour time gap, between the fifth and sixth entries there was a fourteen hour time gap, and between the fifth and sixth entries there was an eight and one half hour time gap.

A review of the Scott Fall Risk Screen initiated for resident #012's incident on an identified date, indicated that that the screen did not indicate the Resident's name, the name or signature of the screener, or the reason the screen was completed.

A review of the Post Fall Assessment Tool initiated for resident #012's incident on a specified date, indicated that the date of the incident was an identified date, but was not completed in entirety and the back of the tool was left blank. The tool did not identify the resident's name, the date of report, whether or not a post fall huddle was completed, main root cause, how the fall may have been prevented, follow-up plan or recommendations, medications that were administered in the last 12 hours leading up to the fall, fall prevention interventions, and the signature of the person who completed the "Post-Fall Assessment Tool."

During an interview with RPN #116, they stated that when a resident had experienced an unwitnessed identified incident, the RPN or RN was responsible for initiating and implementing the "Clinical Monitoring Record" and completing a "Scott Fall Risk Screen" and "Post-Fall Assessment Tool", as soon as possible.

Together with the Inspector, RPN #116 reviewed the documentation for resident #012's accidental, and unwitnessed incident on a specified date. RPN #116 stated that the Clinical Monitoring Record was not completed as it should have been. They stated that the tool should have been completed for 76 hours and it appeared that it was only completed for 36 hours, also that the guidelines for completion of the the form were not followed as pain, vitals and neurological vitals were not assessed every hour for four hours and every eight hours for 72 hours. RPN #116 stated that the Post- Fall Assessment Tool was not fully completed and that most vital information was left blank, including the resident's name, date of report, name of staff who completed the report, and if a post falls huddle was completed. The RPN stated that the Scott Fall Risk-Screen was not completed as it should have been, as it did not include the name of the resident, the name or signature of the screener, or the reason the screen was completed.

During an interview with the Administrator, they stated that when a resident had experienced an unwitnessed identified incident, registered staff were required to assess the resident, complete a falls huddle, Clinical Monitoring Record, Post Fall Assessment Tool, Scott Fall Screen, and a progress note in MED e-care. Together with the Inspector, the Administrator reviewed the documentation for resident #012's incident on an identified date, and stated that the documentation was incomplete and that mandatory assessments were missing. They stated that the home's Falls Prevention and Management program was not implemented as was required for resident #012's incident on an identified date. [s. 48. (1) 1.]

4. The licensee has failed to ensure that the skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was implemented in the home.

a) A written complaint was submitted to the Director regarding resident #017's wound care treatment, weight loss and health decline since admission to the home on an identified date.

Refer to WN #2, finding #6 for further details.

The health care records for resident #017 were reviewed. An identified risk assessment that was completed at the time of admission, indicated the resident was to be at a low risk of areas of altered skin integrity with an identified numerical score. The identified risk assessment completed on a specified date,

indicated the resident had an identified higher numerical score, which identified a high risk of areas of altered skin integrity. The RAI MDS from identified dates, under an identified section, did not identify the use of a pressure relieving device for a chair or for a bed. The Physician's Orders did not include an order for a therapeutic surface on the bed. The care plan from admission through to date of transfer on an identified date, did not identify the use of a therapeutic surface in bed.

Together with Inspector #196, the Best Practice RN, reviewed the licensee's policies within the skin and wound program. The RN confirmed that with the high identified risk score documented on a specified date, and moderate assistance with bed mobility, the "Support Surface Selection Tool - RC-23-01-01-A4 - February 2017", identified that an air bed would have been the recommended support surface for resident #017.

During a further interview with the Best Practice RN, they reported that a nurse's recommendation, an MD order, or OT referral, could initiate the use of an air mattress or therapeutic surface for a resident's bed. They added that the use of a therapeutic surface in bed should have been included in the resident's care plan if it was used as an intervention to maintain skin integrity. They confirmed, after a review of the health care records, that a therapeutic surface in bed was not utilized for resident #017.

b) The licensee's skin and wound program titled "Wound Care Management: Prevention of Skin Breakdown – February 2017 – RC-23-01-01", read, "Ensure that the PURS is completed during quarterly MDS RAI assessment, and more often as required, and that risk mitigation strategies and interventions are implemented to address areas of risk or actual skin impairment".

The health care records for resident #017 were reviewed. The PURS was done after admission on an identified date, and scored an identified numerical score. There was no record that a PURS was conducted in an identified month. A subsequent PURS was conducted on an identified date, and the resident had higher identified numerical score. The care plan that was effective on an identified date, through until the identification of an area of altered skin integrity on an identified date , was unchanged.

During an interview with the Best Practice RN, they reported that the identified date PURS indicated a low risk for areas of altered skin integrity, confirmed the

required quarterly PURS was not done in an identified month, and that the PURS on an identified date, had indicated a high risk for pressure ulcers. They further added, after a review of the care plan, that there had not been any changes implemented to have mitigated the risks of impaired skin integrity as indicated in the PURS assessment on an identified date. They further acknowledged that resident #017, developed an area of altered skin integrity, as identified in an identified assessment completed on an identified date; there were no changes to the plan of care as per the skin and wound care policy; and the resident had gone from a low risk to a high risk for areas of altered skin integrity. [s. 48. (1) 2.]

5. The licensee has failed to ensure that a continence care and bowel management interdisciplinary program was developed and implemented in the home to promote continence and to ensure that residents were clean, dry and comfortable.

During dining observation, it was identified that resident #010 was ordered a specified diet and that the home was not in compliance with legislation related to the ordered diet.

(a) During reviews of resident #020's health care record on identified dates, Inspector #625 observed that the resident's identified record from identified dates, was blank for all required shifts for identified categories. The Assessment Summary section was also blank.

During review of a second recently admitted resident's identified record, Inspector #625 identified that the record reflected resident #021 did not complete an ADL until an identified time on an identified date, only completed the ADL once that shift, and did not have a drink until an identified time on that date. The record also reflected the resident did not complete the identified ADL until an identified time on a specified date, and did not drink until an identified time on that date. The Assessment Summary section was blank.

The Inspector reviewed POC documentation that identified the resident had completed an ADL a specified number of times, prior to an identified time on a specified date, on a specific shift.

A third recently admitted resident, resident #022's identified record from a specified date, was missing records of identified categories for all required dates. The Assessment Summary section was also blank.

The licensee's policy titled, "Continence Care and Bowel Management Toolkit", dated May 2016, identified that registered nursing staff were to initial a three day voiding assessment that included fluid intake, urine voided and incontinence episodes to establish the resident's individual voiding pattern and trends. The three day voiding assessment was to be completed on admission and as required.

During an interview with the Administrator, they stated that the identified records for residents #020, #021 and #022 had not been completed as noted by the Inspector, but should have been.

(b) During reviews of resident #020's health care record on identified dates , Inspector #625 observed that the resident's identified record dated a specified date, did not contain documentation for a specified number of the shifts up to the review date.

During review of resident #021's identified record, dated an identified date, Inspector #625 identified that the record did not contain documentation for a specified number of the shifts listed. In addition, the Assessment Summary section was blank.

The Inspector reviewed POC documentation that identified the resident had completed a normal bodily function during the specific shifts on identified dates.

A third recently admitted resident, resident #022's identified record dated an identified date, identified a specified number, of the shifts contained no documentation, In addition, the Assessment Summary section was also blank.

The licensee's policy titled, "Continence Care and Bowel Management Toolkit", dated May 2016, identified that registered nursing staff were to initial a "7 day bowel elimination assessment" that included consistency, size and incontinence episodes utilizing data from the Daily Resident Care Record".

During an interview with the Administrator, they stated that the identified records for residents #020, #021 and #022 had not been completed as noted by the Inspector, but should have been. [s. 48. (1) 3.]

6. Resident #008 was identified as having a normal functioning bodily process

and as needing an assistive device to complete the same bodily process, as per their Resident Assessment Instrument - Minimum Data Set (RAI-MDS) quarterly review, dated with an identified date.

During interviews with resident #008, they informed the Inspector that their assistive device had been removed on an identified date, they were not of normal functioning for a bodily process, required staff assistance with an ADL and were adjusting to completing the identified bodily process using specified products.

A review of the licensee's "Continence Care and Bowel Management Toolkit – Long-Term Care", dated May 2016, identified that registered nursing staff were to implement relevant strategies to effectively manage and possibly reduce urinary incontinence.

A review of resident #008's Order Sheet and Progress Notes record dated an identified date, by Inspector #625, identified that the resident's assistive device had been removed at an identified time and that a specific diagnostic of the resident was ordered every eight hours for 48 hours. The order detailed that, if the identified volume was greater than or equal to a specified amount, or if the resident was uncomfortable, staff were to replace the assistive device.

Resident #008's current care plan effective a specified date, identified the resident was to have a specific diagnostic completed every eight hours for 48 hours.

A review of electronic progress notes identified that resident #008 had a specific diagnostic completed on identified dates at a specified times. The Inspector was not able to locate data on the ordered date at a specified time and on another specified date and time.

During an interview with the Best Practice RN, they reviewed resident #008's health care record and identified four identified diagnostic test volumes recorded in the record. They stated that not all of the ordered identified diagnostic tests had been completed.

During an interview with the DOC, they reviewed resident #008's health care record and acknowledged the resident was ordered a specified diagnostic test every eight hours for 48 hours after removal of the assistive device. The DOC reviewed the resident's electronic progress notes and identified that an identified number of the identified diagnostic test volumes were absent. [s. 48. (1) 3.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 007

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 programs are developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury; and a continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure residents were not neglected by the licensee or staff.

Ontario Regulation 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-

being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A written complaint was submitted to the Director regarding resident #017's wound care treatment, weight loss and health decline since admission to the home on December 29, 2017.

During an interview with complainant #200 and Inspector #196, they alleged neglect towards resident #017. They reported that they had been told of an area of altered skin integrity at a specified time; they had not seen the area of altered skin integrity themselves, until such time as the resident had been transferred to another healthcare facility in a specified month of an identified year. They indicated they were shocked that the resident had declined like this, had developed a area of altered skin integrity, and that an identified change had occurred.

The licensee failed to provide the resident with the treatment, care, services or assistance required for health, safety or well-being, which included inaction or a pattern of inaction that jeopardized the health, safety or well-being of the resident as follows:

a) With respect to Ontario. Reg. 79/10, s. 59. b), the licensee was required to ensure that therapy services for residents of the home were arranged or provided under section 9 of the Act that included occupational therapy.

The Physician's Orders written by MD #128 on an identified date, indicated for a specific intervention to be put in place by the OT, and on another identified date, indicated that the OT was to assess for another specified intervention, and both orders indicated a referral was sent. The progress notes did not indicate that a OT consultation had occurred as a result of either referral.

During an interview with OT #141,they reported that they had received referrals to see resident #017 on identified dates, via email. The OT provided copies of the email referrals, and both indicated the referrals were upon the physician's request. The OT further reported that they only had three hours per week in the home and needed to prioritize the referrals and sometimes didn't get to see every one. The OT further reported that the resident was not assessed in relation to these referrals and no action was taken as a result of these referrals.

Refer to WN #6, finding #1 for further details.

b) With respect to the Long-Term Care Homes Act (LTCHA), 2007, s. 6. (9) 1, the licensee was required to ensure that the provision of the care set out in the plan of care following was documented.

On October 2, 2018, RD #108 conducted a nutritional assessment on resident #017, based upon a referral by the DOC regarding an intervention.

The health care records for resident #017 were reviewed. The RD orders on an identified date indicated for an intervention to be initiated at specified times. The progress notes written by the RD on this same date identified to initiate the intervention to provide additional calories and protein to resident #017 to support healing of areas of altered skin integrity and weight maintenance. The eMAR identified that the ordered intervention was initiated at a specified time on an identified date. The dietary flow sheets for an identified month indicated the provision of the intervention in specified amounts, on identified dates at specific times.

During an interview with the Best Practice RN, they reported to the Inspector that a new direction had been implemented on an identified date, that changed the process for staff to follow with regard to identified interventions. Specifically, the RPNs were no longer to provide or sign for the administration of identified interventions, as this was now a PSW task.

Together with the Inspector, the Best Practice RN reviewed the dietary flow sheet for the time period after an identified date, and confirmed the identified intervention was not recorded as provided at every specified time to resident #017 as had been ordered.

Refer to WN #2, finding #13 for further details.

c) With respect to Ontario. Reg. 79/10, s. 68. (2) (c), the licensee was required to ensure that the organized program of nutrition care and hydration included the implementation of interventions to mitigate and manage those risks.

The licensee failed to ensure that the nutrition care and hydration programs included, (c) the implementation of interventions to mitigate and manage those risks.

i)On an identified dates, RD #108 conducted a specific assessment on resident #017, based upon a referral by the DOC regarding identified interventions.

The health care records for resident #017 were reviewed. The RD orders on an identified date, indicated for an intervention to be discontinued. Initiate an identified intervention. The progress notes written by the RD on this same date identified that the staff on the floor were unable to notify writer if resident receives the intervention, and to initiate an intervention to provide additional calories and protein to promote healing of areas of altered skin integrity and for weight maintenance. The eMAR identified that the intervention was initiated at a specified time on an identified date.

During an interview with the Best Practice RN, they reported to the Inspector that registered staff had not processed the RD order for an identified intervention on a specified date, one week after the order was originally written.

During an interview with the DOC, they confirmed upon review of the Physician Orders that the second check of the orders was not done by the registered staff for the identified intervention and it was not started until one week after it had been ordered.

Refer to WN #14, finding #1 b), for further details.

ii)On an identified date, the RD #108 conducted an identified assessment on resident #017, as they had developed an identified area of altered skin integrity on an area of their body.

The health care records for resident #017 were reviewed. The Physician's Orders, indicated for an intervention to be added and that the POA was in agreement, additional protein requirements to support healing of areas of altered skin integrity. The care plan in effect at the time of the order included, the addition of the ordered intervention. The eMAR did not include this RD order. The dietary records for identified months, did not include the provision of the identified intervention.

The progress notes written by the RD on an identified date, indicated that the staff on the floor were unable to notify writer if resident receives the intervention as ordered.

During an interview with the DOC, they confirmed upon review of the Physician Orders that the second check of the orders was not done by the registered staff for the identified intervention.

During an interview with RN #123, they reported that if a physician ordered treatment or a RD ordered an intervention, it was to be carried out as ordered.

During an interview with the Best Practice RN, they confirmed to the Inspector that there was no record that identified intervention had been provided at specific times since it had been ordered on an identified date. They further reported that the RD order had only one initial of a registered staff that had processed the order; should have had two checks by registered staff; and the order had never been put into the eMAR.

During an interview with the Administrator, they were informed that there was no record of the identified intervention having been provided to resident #017 as indicated in the RD orders written on an identified date. They further reported they would have expected that it would have been provided as ordered.

Refer to WN #14, finding #1 a), for further details.

d) With respect to the Long-Term Care Homes Act (LTCHA), 2007, s. 6. (4). (a), the licensee was required to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

i) The licensee policy titled, "Interdisciplinary Wound Care Team Roles - February 2017 - RC-23-01-01-A1" indicated that the nurse "Informs Wound Care Lead, Physician/NP of any new and/or worsening skin breakdown and as needed" and "Monitors all wounds with every dressing change".

The Physician's Orders from MD #128 identified that resident #017's area of altered skin integrity had not been assessed or observed after an identified date, through to a later identified date, as during those MD visits the resident was up. The Physician's Orders from an identified date indicated that if there were concerns about resident #017's areas of altered skin integrity then staff were to email a photo to the MD's email address, as provided, and on another identified

date the same orders for concerns on another identified area of altered skin integrity.

The identified assessment tool, initiated on an identified date, indicated the area of altered skin integrity's measurements and characteristic, which according to the legend indicated a characteristic of the area. Documented identified assessments and dressing treatments on specified date, identified a specific rating, which indicated an identified characteristic. On an identified date, the area of altered skin integrity was identified as specified numerical score which indicated an identified characteristic. On identified dates, the base of the area of altered skin integrity was identified as a specified numerical score, which indicated a more severe characteristic.

The measurements as documented on the identified assessment, from a specified date range, were a specific measurement, with depth recorded between a specific measurement. There were no measurements completed on identified dates.

On an identified date, the physician's notes as recorded on the Physician Orders sheet, indicated the area of altered skin integrity was at least a certain measurement having a specific characteristic.

During an interview with the Best Practice RN, the progress notes were reviewed with the Inspector. There was no record of any emails with pictures sent to the MD, despite the area of altered skin integrity having been assessed as having progressed from a specific characteristic to another characteristic.

During an interview, the DOC, they reported to the Inspector, that as indicated in the identified assessment tool, the area of altered skin integrity progressed from a specific characteristic to another characteristic, which indicated a worsening and the physician should have been notified.

Refer to WN #2, finding #6 a), for further details.

ii) Inspector #196 reviewed the "Pain Management Toolkit" May 2016, as provided as the licensee's pain management program. The toolkit included the following: Interprofessional Team Monitoring, Registered Nursing Staff: "Ongoing assessment is done in collaboration with resident/family/SDM and other team members: when a resident exhibits a change in health status or pain is not relieved by initial interventions…for example PSW reports resident's experience

of pain…" and "indicates that pain is present through family/staff/volunteer observation".

The "Pain Management Protocol (PSW)" indicated that the PSW staff were to document on flow sheet and in Med e-care…"PSW Reports to the RPN or RN". The "Pain Management Protocol (RN/RPN)" indicated upon "Direct report of resident in pain" then "RPN/RN completes pain assessment and documents".

The health care records for resident #017 were reviewed specific to pain. The care plan in effect, in an identified month indicated an area of pain, with a specific focus and expected outcome that the resident would be comfortable at all times, as well as an intervention to observe for signs of pain and report to Registered Staff when the resident was experiencing pain. The eMAR indicated the resident was started on an identified medication, on a specified date, and also had a PRN medication dose. The PRN administration history identified that a dose of the identified medication was last given on a specified date, for an unknown reason. No further PRN analgesia was documented as provided after this date through to another identified date. The progress notes were reviewed for an identified time period , and there was no indication recorded of resident pain.

During an interview, PSW #129 reported to Inspector #196 that they recalled having provided care to resident #017. In regard to discomfort, PSW #129 stated that this resident would respond in a specific way when they were repositioned in bed and they were in pain sometimes when turned in bed. PSW #129 was identified as #3 staff on the POC records for an identified month, and reported that if pain was observed during care then they would check pain for that resident on that shift in POC.

During interviews with PSW #129 and PSW #114, they demonstrated to the Inspector, the POC charting for pain experienced by a resident. There was an area to check off titled, "complained or shows evidence of pain"; an area to record either verbal or observed complaints of pain and had check marks to indicate these complaints; and check mark area which read, "any pain symptoms should be reported to registered staff and documented". Both PSWs #129 and #114 reported that they would mark this off every shift, if a resident had pain, pain daily, and if the resident had reported either verbally or was observed to have pain and if reported to the nurse.

During an interview with the Best Practice RN, they reviewed resident #017's

Flow Sheets from an identified month, in POC. The Flow Sheets from a specified date range, indicated that resident #017 was documented as having indicated pain symptoms less than daily on a specific number of shifts; physical signs of pain observed on a specific number of shifts; verbal complaints of pain on a specific number of shifts; and it was also documented on a specific number of shifts that any pain symptoms should be reported to registered staff and documented.

The Best Practice RN confirmed to the Inspector, that the most recent quarterly pain assessment was done on an identified date, which indicated a specified level of pain; the specific source, and identified tissues. The Best Practice RN further reported, there were no additional pain assessments completed after this date.

During an interview with the DOC, when questioned where the PSWs would record resident "pain symptoms", they reported it would be on the POC flow sheets. They further reported that there would be documentation in the eNotes and pain assessments that would reflect the communication of resident pain by the PSWs to the registered staff. The DOC reported to the Inspector, that they would expect some record of the communication of pain to the registered staff with regard to the POC documentation of pain from an identified date range, for resident #017. The DOC then confirmed the PSW documentation of observed resident pain in an identified month, had increased since the last pain assessment completed on an identified date, as this pain assessment noted the resident was comfortable with the current pain control.

Refer to WN #2, finding #6 b), for further details.

e) With respect to the Long-Term Care Homes Act (LTCHA), 2007, s. 6. (7), the licensee was required to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

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.

The licensee's skin and wound program titled "Wound Care Management – February 2017 – RC-23-01-02", read, "Document all skin breakdown in the interdisciplinary progress notes (or wound progress note) and in surveillance tools".

The health care records for resident #017 were reviewed for information regarding the provision of care to an area of altered skin integrity. The care plan included the intervention of an identified treatment for the area of altered skin integrity. The Physician's Orders, from an identified date, indicated specific treatments for the area of altered skin integrity. The identified assessment tool for the specified month, did not have documentation of the ordered treatment or completed assessments on identified dates.

During an interview with the Best Practice RN, they reported to the Inspector that the registered staff were to fill out the identified assessment tool every time the treatment was completed. They further reported this tool also served as the weekly wound assessment.

During an interview with the DOC, they confirmed to the Inspector, upon review of the identified assessment tool, that the physician ordered treatments were not documented as completed on identified dates. They further reported if the treatment was "not charted, it was not done".

Refer to WN #2, finding #12 for further details.

f) With respect to Ontario. Reg. 79/10, s. 48. (1). 2, the licensee was required to ensure that the following interdisciplinary programs were developed and implemented in the home: 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.

The licensee has failed to ensure that the skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was implemented in the home.

i)The licensee's skin and wound program titled "Wound Care Management: Prevention of Skin Breakdown – February 2017 – RC-23-01-01", read, "Ensure that the PURS is completed during quarterly MDS RAI assessment, and more often as required, and that risk mitigation strategies and interventions are implemented to address areas of risk or actual skin impairment".

The health care records for resident #017 were reviewed. The identified

assessment was done after admission on an identified date, and scored a specified numerical score. There was no record that an identified assessment was conducted in a specified month. A subsequent identified assessment was conducted on an identified date, and the resident had a numerical score. The care plan that was effective on an identified date, through until the identification of an area of altered skin integrity, was unchanged.

During an interview with the Best Practice RN, they reported that the identified month identified assessment indicated a low risk for areas of altered skin integrity, confirmed the required quarterly identified assessment was not done in an identified month, and that the identified assessment completed on a specified date, had indicated a high risk for areas of altered skin integrity. They further added, after a review of the care plan, there had not been any changes implemented to have mitigated the risks of impaired skin integrity as indicated in the identified assessment on a specified date. They further acknowledged that resident #017, developed an area of altered skin integrity, as identified in an identified assessment tool dated a specified date; there were no changes to the plan of care as per the skin and wound care policy; and the resident had gone from a low risk to a high risk for areas of altered skin integrity.

Refer to WN #7, finding #4 b), for further details.

ii) The identified assessment completed at the time of admission, on an identified date, indicated the resident to be at a low risk of areas of altered skin integrity with a specified numerical score. The identified assessment completed on an identified date, indicated the resident had a higher numerical score, which identified a high risk for areas of altered skin integrity. The RAI MDS dated a specified date, and on another specified date, under a specified section; did not identify the use of a pressure relieving device for a chair or for a bed. The Physician's Orders did not include an order for a therapeutic surface on the bed. The care plan from admission through to date of transfer, did not identify the use of a therapeutic surface in bed.

Together with Inspector #196, the Best Practice RN, reviewed the licensee's policies within the skin and wound program. The Best Practice RN confirmed that with the high risk identified assessment score on a specified date, and a specified level of assistance with bed mobility, the "Support Surface Selection Tool - RC-23 -01-01-A4 - February 2017", identified that an air bed would have been the

recommended support surface for resident #017.

During a further interview with the Best Practice RN, they reported that a nurse's recommendation, an MD order, or OT referral, could initiate the use of an air mattress or therapeutic surface for a resident's bed. They added that the use of a therapeutic surface in bed should have been included in the resident's care plan if it was used as an intervention to promote wound healing. They confirmed, after a review of the health care records, that a therapeutic surface in bed was not utilized for resident #017.

Refer to WN #7, finding #4 a), for further details.

In summary, resident #017 was not provided with the treatment, care, services, or assistance required for their health, safety or well-being, in areas related to the skin and wound care program. [s. 19. (1)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 008

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of residents were fully respected and promoted, including the right to be afforded privacy in treatment and in caring for his or personal needs.

Inspector #625 reviewed the home's pharmacy provider's policy, titled, "Medication Policies and Procedures for Long-Term Care", section 6.14 titled [Injectable] Administration, revised in September of 2018. The policy identified that staff were to provide for resident privacy when administering [the injectable medication].

On March 13, 2019, Inspector #625 observed RPN #110 leaving the an identified home area during a specified meal service with an injectable medication device

and alcohol wipe.

During an interview with RPN #110, they stated that they had administered resident #020's medication to them in an identified area of their body, in the identified home area and that residents should not be administered the specific medication in the identified home area and that they usually did not do so.

On an identified date, Inspector #625 observed RPN #111 administer a specified medication to resident #025 in the identified home area during a specified time. The RPN pulled the right side of the resident's pants down and the right side of their shirt up, exposing their right lower abdomen. The RPN then administered the identified medication to the resident while they sat at a table with two other residents, while one of the residents noticeably watched them complete administration process.

During an interview with RPN #111, they stated that administering the identified medication into residents' abdomens in the specified home area was their usual practice.

During an interview with the Best Practice RN, they stated that residents #020 and #025 should not have had the identified medication administered to them in their abdomens in the dining room without privacy being maintained. The Best Practice RN stated that privacy screens had been purchased so that staff could administer the identified medication to residents behind the privacy screens. The Best Practice RN also acknowledged that exposing resident's abdomens for the injection was not dignified and that privacy of the injections was required.

During an interview with the Administrator, they stated that the residents noted by the Inspector, should not have had the identified medication administered to them in their abdomens while in the specified home area. The Administrator stated that privacy screens had been purchased for staff to use when administering the identified medication to resident and that staff were required to use the screens to provide privacy during the administration. [s. 3. (1) 8.]

2. The licensee failed to ensure that the following rights of residents were fully respected and promoted: 11. Every resident has 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. 2007, c. 8, s. 3 (1).

During a walk through tour, Inspector #196 observed large sized white dry erase boards affixed on the walls behind nursing desks on the second and the third floors. The information on the boards included resident room numbers and transfer assistance required by the resident. The information was clearly visible to anyone that may be positioned at the nursing desk or walking by the desk.

The College of Nurses of Ontario Practice Standard titled "Confidentiality and Privacy—Personal Health Information" 2017, indicated the following:
- "Personal health information is any identifying information about clients that is in verbal, written or electronic form"; and
- "Clients do not have to be named for information to be considered personal health information. Information is "identifying" if a person can be recognized, or when it can be combined with other information to identify a person. Personal health information can also be found in a "mixed record," which includes personal information other than that noted above".

The licensee's policy titled, "Privacy of Personal Health Information", HLR 9-100, approved September 1, 2016, identified:
- "St. Joseph's care Group (SJCG) recognizes that all personal health information deserves to be treated with respect and sensitivity. SJCG further acknowledges that this information is protected by law under the Personal Health Information Protection Act (PHIPA)."
- Personal Health Information (PHI) "Identifying information (verbal or documented) about an individual's physical or mental health or about the provision of health services to the individual. Individuals can be living or deceased".

During an interview with the RAI Coordinator, they stated to Inspector #196, that the previous DOC had decided to put the white boards behind the nursing desk with information posted on it. They further acknowledged that the posting of resident's transfer status and needs was personal health information (PHI).

During an interview with the Best Practice RN, regarding the white boards at the nursing desks, they reported that they had been moved out to the nursing desk a while ago; can't put very much information on the board because of privacy; and the boards used to be in the room where the charts were kept and then more information could be written on the boards. They confirmed to the Inspector that

transfer assistance, independent transfer, and other resident specific interventions were posted on the white boards and this would be considered PHI.

During an interview with the Administrator, they reported that the previous DOC had decided to place the white boards behind the nursing desk. They then confirmed to Inspector #196, that the posting of resident room numbers with associated transfer status, specific type of lifts to be used and the use of other interventions was the posting of PHI. [s. 3. (1) 11. iv.]

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 rights of residents are fully respected and promoted: every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs; and every resident has the right to, have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rules were complied with: 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they were not being supervised by staff.

On March 4, 2019, during observations on the second floor unit, the doors to utility room #246, and utility room #251 were found to be unlocked and a strap from a lift device was wedged in the bottom of the door. Staff were not observed within either of these areas.

During an interview, PSW #142 reported that the doors to the utility rooms were supposed to have been locked. The PSW proceeded to remove the strap that was wedged in the bottom of the door and the lock engaged.

During an interview, the Environmental Services Supervisor (ESS) was informed by Inspector #196 that the utility room doors #246 and #251, had been unlocked. The ESS reported that they could not ever recall these doors being unlocked and that they were to be locked at all times. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rules are complied with: all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a 24-hour admission care plan was developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home.

During a dining observation, it was identified that resident #010 was ordered a specified diet and that the home was not in compliance with legislation related to the ordered diet. During further inspection, resident #020 was also identified to be receiving a specified diet.

During a review of resident #020's health care record on an identified date and time, Inspector #625 identified that the resident's LTC 24 Hour Resident Care Plan was blank. The resident label on the care plan identified the resident was admitted on an identified date.

A review of the policy in use in the home titled, "Care Planning", last updated April 2017, identified that staff were required to complete a 24 hour admission care plan that was developed immediately after admission, based on information obtained during the admission process.

During an interview with PSW #144, they stated that they had provided care to resident #020 on a specified date, and that they had not had a 24 hour care plan to refer to.

During an interview with the RAI Coordinator, they stated that the LTC 24 Hour Resident Care Plan should be completed for each new resident admission upon arrival. The RAI Coordinator acknowledged that, resident #020's LTC 24 Hour Resident Care Plan was blank and had not been initiated or completed.

During an interview with the Administrator, they acknowledged that resident #020's LTC 24 Hour Resident Care Plan should have been completed within 24 hours of admission, that the resident was admitted on a specified date, but as of the identified shift on a specified date, the 24 hour care plan was blank. [s. 24. (1)]

2. The licensee has failed to ensure that the 24-hour admission care plan identified the resident and included, at a minimum, the following with respect to the resident: diet orders, including food texture, fluid consistencies and food restrictions.

During a dining observation, it was identified that resident #010 was ordered a specific diet and that the home was not in compliance with legislation related to the ordered diet. During further inspection, resident #020 was also identified to be receiving a specific. diet.

During a review of resident #020's health care record on an identified date, Inspector #625 identified that the resident's LTC 24 Hour Resident Care Plan was blank. The Inspector also noted that the care plan document did not contain a section to complete related to the resident's diet orders. The resident label on the care plan identified the resident was admitted on an identified date.

During the review of a second recently admitted resident, Inspector #625 identified that resident #021's undated LTC 24 Hour Resident Care Plan, also did not contain a section to complete related to the resident's diet orders. The

resident label on the care plan identified the resident was admitted on an identified date.

A third resident, resident #022, did not have a LTC 24 Hour Resident Care Plan in their health care record but did have a Kardex dated an identified date, which did not contain a section identifying the resident's diet orders. Resident #022's care plan effective an identified date, and printed on another identified date, indicated the resident was admitted on an identified date.

A review of the policy in use in the home titled, "Care Planning", last updated April 2017, identified that staff were to ensure that the 24 hour admission care plan was completed and communicated to staff within 24 hours and was to include, at minimum, diet orders including type, texture, fluid consistency and food restrictions.

During an interview with PSW #20, they stated that resident #022 had not had a LTC 24 Hour Resident Care Plan in place in the PSW binder, but did have the kardex dated an identified date, in the binder.

During interviews with the RAI Coordinator, they stated that the LTC 24 Hour Resident Care Plan document did not contain an area for staff to record residents' diet orders, including food texture, fluid consistencies and food restrictions, and so the documents for residents #020 and #021, whether completed or not, did not identify the resident's diet orders. The RAI Coordinator reviewed resident #022's chart and stated the resident did not have a LTC 24 Hour Resident Care Plan completed. The RAI Coordinator also reviewed resident #022's kardex dated an identified date, the date of their admission, and identified it did not identify the diet orders for the resident. [s. 24. (2) 8.]

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 ensure that the 24-hour admission care plan must identify the resident and must include, at a minimum, the following with respect to the resident: diet orders, including food texture, fluid consistencies and food restrictions, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident was included in the resident's plan of care.

a) Resident #011 was observed by Inspector #625 to have been in bed, with an intervention in place on the bed.

Inspector #693 made further observations of resident #011 on identified dates.

During these observations, resident #011 was observed laying in their bed with a potential restraint in place on the bed.

A review of resident #011's most current care plan and kardex, last updated on an identified date, did not identify the use of the potential restraint.

During an interview with PSW #106, they stated that if a resident utilized a restraint, the use of the device would be listed on the resident's care plan and kardex. PSW #106 identified that resident #011 utilized an identified restraint, at all times while they were in bed; as a restraint. PSW #106 reviewed the most current care plan and kardex for resident #011, last updated on an identified date, and stated that the use of the restraint was not listed on either document.

During an interview with RPN #110, they stated that if a resident utilized a restraint, the restraint would be identified on the care plan and kardex. RPN #110 stated that resident #011 utilized restraints, including; the identified restraint while in bed. The RPN stated that the restraint was not identified on resident #011's most recent care plan and that it should have been.

Inspector #693 obtained a copy of the home's policy, titled, "Least Restraints, RC-22-01-01", last updated February 27, 2019. The policy stated that a resident who used restraints should have a developed care plan with the goal of restraint reduction, and that all use of restraints must have been clearly detailed in the resident's care plan.

During an Interview with the Administrator, they confirmed that resident #011 utilized a restraint while in bed and that the restraint was not listed on resident #011's most recent care plan.

b) Resident #011 was observed by Inspector #625 to have been utilizing identified potential restraints.

Inspector #693 made further observations of resident #011 on identified dates. During these observations, resident #011 was observed to be utilizing an identified potential restraint.

Inspector #693 reviewed the most current care plan and kardex for resident #011, last updated on an identified date. The care plan, identified that resident #011 sometimes leaned very forward in their ambulation device, to have reached for

something and that staff were to position the ambulation device as needed. Inspector #693 identified that the "Restraints" section of the care plan did not identify the use of the identified restraint.

Inspector #693 reviewed resident #011's medical record and did not identify an order or consent for the use of the identified restraint.

Inspector #693 reviewed resident #011's Restraint Record form, and identified that there was no monitoring or evaluation of resident #011's identified restraint, every eight hours, or at any time completed for the identified time period, and that there was no Restraint Record at any time while the resident lived in the home for the use of the identified restraint.

During an interview with PSW #106, they stated that if a resident utilized a restraint, the use of the device would be listed on the resident's care plan and kardex. PSW #106 identified that resident #011 utilized an identified restraint. PSW #106 reviewed the most current care plan and kardex for resident #011, last updated on an identified date, and stated that a specific device, was not identified on the care plan or kardex as a restraint.

During an interview with RPN #110, they stated that if a resident utilized a restraint, the restraint would be identified on the care plan and kardex. RPN #110 stated that resident #011 utilized an identified restraint as a restraint because the resident often leaned forward to reach, and so required the restraint to prevent them from falling out of the ambulation device. The RPN stated that the identified device was not identified on resident #011's most recent care plan or kardex and that it should have been.

During an Interview with the Administrator, they stated that any restraint that a resident utilized should have been identified on their plan of care. The Administrator acknowledged that resident #011's identified restraint was not identified as a restraint on the most recent care plan. [s. 31. (1)]

2. The licensee failed to ensure that the restraining of a resident by a physical device was included in a resident's plan of care only if all of the following were satisfied: a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

a) Resident #011 was observed by Inspector #625 to have been utilizing identified

restraints.

Inspector #693 made further observations of resident #011 on identified dates. During these observations, resident #011 was observed to be utilizing identified restraints. On each of these occasions, Inspector #693 asked resident #011 to release an identified restraint, and the resident was unable to perform the task.

Inspector #693 reviewed the most current care plan for resident #011, last updated on an identified date. The care plan identified that staff were to monitor resident #011 hourly, when seated in an ambulation device and to have ensured that their identified restraint was fastened at all times when in the ambulation device.

Inspector #693 reviewed resident #011's medical record and identified that there was no current order by a physician, registered nurse in the extended class or other person provided for in the regulations for the use of an identified restraint. Upon review of resident #011's medical record, the Inspector identified that the identified restraint had been ordered and re-ordered as a restraint previously (ongoing since an identified year), but was discontinued as a restraint on an identified date. Inspector #693 reviewed the doctor's order sheets and identified that on a specified date, in the nursing notes section of the order, a nurse had documented that the identified restraint was reclassified as a Personal Assistance Services Device (PASD).

Inspector #693 reviewed the progress notes for resident #011, electronically. A progress note, from an identified date, composed by the Best Practice RN identified that resident #011's identified restraint was no longer classified as a restraint.

During an interview with PSW #106, they stated that resident #011 utilized an identified restraint while in their ambulation device, as a restraint. PSW #106 stated that the identified restraint was a restraint as the resident was not able to undo the identified restraint.

During an Interview with RPN #110 they stated that resident #011 utilized an identified restraint. RPN #110 stated that the use of this identified restraint was considered a restraint as the resident was not able to undo the identified restraint. Together with the Inspector, RPN #110 reviewed the physician's orders for resident #011 and confirmed that there was no current order for the use of the

identified restraint as a restraint for resident #011.

Inspector #693 obtained a copy of the home's policy, titled, "Least Restraints, RC-22-01-01", last updated February 27, 2019. The policy indicated that an order for restraint use was needed for all restraints, as well that part of the planning stage of the home's procedure included obtaining a physician's order for the restraint.

During an interview with the Best Practice RN, they explained that they had speculated that the identified restraint was only being used for positioning reasons for resident #011. The Best Practice RN reviewed resident #011's current care plan and indicated that, if staff were utilizing the identified restraint for resident #011 in the way in which the care plan stated, and to prevent the resident from falling that the identified restraint would be considered a restraint and would require an order.

During an interview the Administrator, they stated that the identified restraint was in place for resident #011 to prevent falls, and that the identified restraint was not aiding to the ability for resident #011 to complete an ADL. The Administrator acknowledged that all restraints in the home required a valid and current order.

b) Resident #011 was observed by Inspector #625 to have been utilizing an identified restraint.

Inspector #693 made further observations of resident #011 on identified dates. During these observations, resident #011 was observed to be seated in an ambulation device, positioned in a way that indicated it was a potential restraint.

Inspector #693 reviewed the most current care plan and kardex for resident #011, last updated on an identified date. The care plan indicated that resident #011 sometimes leaned very forward in ambulation device, to have reached for something and that staff were to position the ambulation device as needed.

Inspector #693 reviewed resident #011's medical record and identified that there was no current order by a physician, registered nurse in the extended class or other person provided for in the regulations for the use of the identified restraint

During an interview with PSW #106, they stated that resident #011 utilized an ambulation device that was sometimes positioned as a restraint.

During an interview with RPN #110, they stated that resident #011 utilized an identified restraint because the resident often leaned forward to reach, and so required the restraint to prevent them from falling out of the ambulation device. Together with the Inspector, RPN #110 reviewed the physician's orders for resident #011 and confirmed that there was no current order for the use of the identified restraint for resident #011.

During an interview the Administrator, they stated that resident #011's ambulation device was positioned as a restraint to prevent falls, and that the identified restraint was not aiding to the ability for resident #011 to complete an ADL. The administrator acknowledged that all restraints in the home required a valid and current order. [s. 31. (2) 4.]

3. The licensee failed to ensure that the restraining of a resident by a physical device was included in a resident's plan of care only if all of the following were satisfied: the restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #011 was observed by Inspector #625, on an identified date to have been utilizing a potential restraint.

Inspector #693 made further observations of resident #011 on identified dates. During these observations, resident #011 was observed to be seated in an ambulation device, positioned as a potential restraint.

Inspector #693 reviewed the most current care plan and kardex for resident #011, last updated on an identified date. The care plan indicated that resident #011 sometimes leaned very forward in ambulation device, to have reached for something and that staff were to position the ambulation device as needed.

Inspector #693 reviewed resident #011's medical record and identified that there was no consent by the resident or SDM for the use of the identified restraint.

During an interview with PSW #106, they stated that resident #011 utilized an identified restraint.

During an interview with RPN #110, they stated that resident #011 utilized an

identified restraint because the resident often leaned forward to reach, and so required the restraint to prevent them from falling out of the ambulation device. RPN #110 stated that every restraint in the home required consent from a Resident or SDM to be in use. Together with the Inspector, RPN #110 reviewed resident #011's medical record and confirmed that there was no current consent for the use of the identified restraint for resident #011.

Inspector #693 obtained a copy of the home's policy, titled, "Consent for Restraint Use, RC-22-01-02", last updated February, 2017. The policy stated that a restraint could only be used if a consent was obtained, and that the Nurse should indicate on the consent, by use of a check mark, that each identified risk had been explained to the resident or SDM. Inspector #693 also obtained a copy of the home's policy, titled, "Least Restraints, RC-22-01-01", last updated February, 2017. The policy indicated that when restraint use was being planned, the Nurse was to have obtained a consent that was required from the resident, where possible or the SDM.

During an interview the Administrator, they acknowledged that all restraints in the home required a consent from the Resident or SDM. [s. 31. (2) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care; and that the restraining of a resident by a physical device is included in a resident's plan of care only if all of the following are satisfied: a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee of a long-term care home shall ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items.

During the initial tour of the home, Inspector #196 observed, in the second floor south end tub room, two stick deodorants, “Arrid” and “Secret”, three soiled black combs, two hairbrushes that had debris and loose hair. The Inspector, observed in the north end tub room: two stick deodorants, “Arrid” and “Secret”, a blue and a black comb.

During an interview, PSW #121, together with Inspector #196 went to the second floor tub rooms and confirmed the following unlabelled personal care items:
In the south side tub room:
- one labelled hairbrush "with an identified name", soiled with hair and debris, PSW #121 reported this resident no longer resided in the home;
- used denture brush;
- one black comb, soiled; and
- one "Arrid" and one "Secret" stick deodorants.
In the north side tub room:
- two used deodorants, one black and one blue combs soiled withe debris/hair;
- a clear plastic basket beside the tub that contained a used toothpaste tube, toothbrush, nail brush, two used razors, PSW #121 stated they didn't know who these items in the plastic basket belonged too; and
- a urinal positioned in the north side tub room beside the toilet, the PSW did not

know to whom this belonged.
The PSW stated the PSWs were to label these items when the resident was admitted to the home, or received new items.

In the third floor south end tub room, Inspector #196 observed a hair brush soiled with debris. The north end tub room on the third floor, had a "secret" stick deodorant and "Aim" toothpaste.

During an interview, with PSW #145, they confirmed to Inspector #196 that hair brushes, combs, deodorant, and all personal items, were to be labelled with the residents' name. They further confirmed that they did not know to whom these personal items had belonged to.

Inspector #625 conducted observations and identified the following unlabelled and used personal care items in shared washrooms:
- identified room - a toothbrush;
- identified room - a toothbrush, hair brush, and numerous creams;
- identified room - two hair brushes, two combs, a toothbrush, and toothpaste;
- identified room - two hair brushes, one hair comb, and body wash;
- identified room - two hair brushes, hair comb, blue and white toothbrush;
- identified room - two hair combs, one denture brush, and toothpaste;
- identified room - three hair combs, hair gel, one toothbrush, multiple razors, one denture brush;
- identified room - one hair brush; and
- identified room- one slipper pan.

The "Admission Checklist" that was provided as the home's process for labeling personal items, indicated that the PSWs were responsible for labeling toiletries and belongings.

During an interview, the Administrator reported that resident's personal items were to be labelled and that this was the PSW's responsibility. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and hydration programs included, (c) the implementation of interventions to mitigate and manage those risks.

A written complaint was submitted to the Director regarding resident #017's wound care treatment, weight loss and health decline since admission to the home on December 29, 2017.

Refer to WN #2, finding #6 for further details.

a) On an identified date, RD #108 conducted a nutritional assessment on resident #017, as they had developed an area of altered skin integrity.

The health care records for resident #017 were reviewed. The Physician's Orders from an identified date, indicated for an intervention to be added in the resident's plan of care, POA in agreement, additional intervention to promote healing of areas of altered skin integrity. The care plan in effect at the time of the order included the addition of this identified intervention. The eMAR did not include this RD order. The dietary records for identified months, did not include the provision of the identified intervention.

During an interview with RN #123, they reported that if a physician ordered a treatment or a RD ordered an intervention, it was to be carried out as ordered.

During an interview with the Best Practice RN, they confirmed to the Inspector that there was no record that the identified intervention had been provided, since it had been ordered on an identified date. They further reported that the RD order had only one initial of a registered staff that had processed the order; should have had two checks by registered staff; and the order had never been put into the eMAR.

During an interview with the Administrator, they were informed that there was no record of the identified intervention having been provided to resident #017 as indicated in the RD orders written on an identified date. They further reported they would have expected that it would have been provided as ordered.

b)On an identified date, RD #108 conducted a nutritional assessment on resident #017, based upon a referral by the DOC regarding an identified intervention.

The health care records for resident #017 were reviewed. The RD orders on an identified date,indicated to discontinue an identified intervention, and to initiate another identified intervention.The progress notes written by the RD on an identified date, indicated that the staff on floor were unable to notify writer if

resident receives the identified intervention and to initiate the other identified intervention to support areas of altered skin integrity healing and weight maintenance. The eMAR identified that the newly ordered, identified intervention, was initiated at a certain time, on an identified date.

During an interview with the Best Practice RN, they reported to the Inspector that registered staff had not processed the RD order for the identified intervention until an identified date, one week after the order was originally written.

During an interviews with the DOC, they confirmed upon review of the Physician Orders that the second check of the orders was not done by the registered staff for the either of the identified interventions; as well, that the newly ordered, identified intervention, was not started until one week after it had been ordered. [s. 68. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the nutrition care and hydration programs include, the implementation of interventions to mitigate and manage those risks, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle included menus for regular, therapeutic and texture modified diets for both meals and snacks.

During an interview with resident #010, they informed Inspector #625 that they were on an identified diet.

During an observation of an identified meal service on a specified date, Inspector #625 observed resident #010 served an identified food item, which was not an item listed on the posted menu.

During an interview with DA #130, they stated that resident #010 was on an identified diet, the food item was sent specifically for the resident from the kitchen, the resident did not have a second identified diet item to choose from and identified diet meal items were not posted.

During an interview with the FSS , they stated that the home did not have separate menus for identified diet types. The FSS stated that the home modified or substituted items listed on the regular menu cycle for residents requiring therapeutic diets such as identified diets, but did not have menus for these diets. [s. 71. (1) (b)]

2. The licensee has failed to ensure that the home's menu cycle included alternative choices of entrees, vegetables and desserts at lunch and dinner.

(a) During observations of meal services, Inspector #625 observed resident #010

served food items without being offered an alternative choice of meal.

During interviews with resident #010, they stated that they had a special diet and were not offered an alternate meal choice.

A review of resident #010's Medication Reconciliation form an identified date, indicated the resident was ordered an identified diet type.

During an interview with PSW #146, they stated that resident #010 was given a n identified food item for a specific meal, as that was the only choice the resident had that was in line with their diet. The PSW stated the resident could always ask for a second choice from the entrees for regular diets and the resident could pick something outside of their diet, as it was up to the resident if they wanted to do that, so that the regular food items would be the resident's second choice.

During an interview with DA #130, they stated that resident #010 was on an identified diet, meal items were sent specifically for the resident from the kitchen and the resident did not have a second identified diet meal item to choose from. During a subsequent interview with the DA, they had obtained a document titled "Bethammi Fall/Winter Working Copy 2018" which identified circled items from the regular menu cycle and had resident #010's name written on it. The Dietary Aide stated the resident was served variations of the circled items.

During an interview with the FSS, they stated that they had reviewed the [regular] menu with resident #010 in an identified month, and the resident picked items they wanted. The FSS stated the identified season menu started in an identified month, was still in use, and would end around another identified month. The FSS acknowledged that the resident had been receiving the same menu items, chosen in an identified month, repeating every three weeks, for over three months. During a subsequent interview, the FSS acknowledged that the items listed on the regular menu they had reviewed with the resident in an identified month, included items that the resident would be unable to choose as they were not in accordance with the resident's dietary restrictions such as identified foods. The FSS also acknowledged that the resident had not been provided with alternate choices in accordance with their dietary restrictions when they had reviewed the regular diet in an identified month.

(b) During an interview with Dietary #147, they identified resident #020 had been recently admitted to the home, required an identified diet type, was provided with

a special food item during the specified meal and had not been offered an alternative choice.

During an interview with resident #020, they stated that they had been provided with an identified food item and had not been offered a choice during the specified meal.

A review of the resident #020's Medication Reconciliation Order Form New Admission From Home/Respite documented dated an identified date, indicated the resident was ordered an identified diet type.

During an interview with the FSS, they stated that resident #020 had been admitted to the home two days prior and should have been provided with two choices at meals, even if they needed an identified diet type.

During an interview with the Administrator, they stated that the home was required to provide residents on therapeutic diets with alternate meal choices. [s. 71. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's menu cycle includes menus for regular, therapeutic and texture modified diets for both meals and snacks, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

During dining observation, it was identified that resident #010 was ordered an identified diet type and that the home was not in compliance with legislation related to the ordered diet.

During an interview with the FSS, Inspector #625 asked how the home's RD could be reached. The FSS stated that RD #108 was no longer working as the RD for the home but was fulfilling some hours outside of another job they worked. The Food Services Supervisor stated that RD #109 had been hired and had attended the licensee's off site orientation beginning on February 25, 2019.

A review of RD hours provide by the FSS, identified the RD hours worked on site 45 hours in January 2019, and 19.5 hours onsite in February 2019.

A review of Census Detail Reports for January and February 2019, identified the home had 113 and 112 residents admitted in the home each month, respectively.

Inspector #625 calculated the amount of required RD time on site for January and February, 2019, as 56.5 hours and 56 hours, respectively.

During subsequent interviews with the FSS, they acknowledged that the RD(s) had not worked on site for the minimum amount of time required in January and February 2019. [s. 74. (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 a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: that the resident was monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

a)Resident #011 was observed by Inspector #625 to have been in bed, with an intervention in use on their bed.

Inspector #693 made further observations of resident #011 on identified dates. During these observations, resident #011 was observed laying in their bed with the identified intervention in place.

Inspector #693 completed a review of resident #011's medical record. Resident #011's medical record contained a valid order from a physician for the identified intervention, as well as a signed consent form, from resident #011's Substitute Decision Maker (SDM) allowing the use of the identified intervention.

During an interview with PSW #106, they stated that if a resident utilized a restraint, the PSW was responsible for monitoring them hourly, on a form entitled, "Restraint Record". PSW #106 stated that located in each locked supply cart, for each personal support section in the home, there was a binder that contained the restraint record sheets for each resident in that section who utilized a restraint. PSW #106 stated that Resident #011 utilized the identified intervention, at all times while they were in bed; as a restraint. Together with the Inspector, PSW #106 reviewed the Restraint Record for resident #011, for "the identified intervention, for the specified month, and stated that there was missing hourly documentation on an identified date; for specific shifts, on an identified date; for a specific shift, and on an identified date; for a specific shift.

During an Interview with RPN #111, they stated the PSWs were responsible for monitoring a resident's restraint every hour and that the RPNs were responsible for monitoring a resident's restraint every eight hours on each Resident's Restraint Record form. They stated that resident #011 utilized an identified intervention as a restraint. RPN #111 reviewed the restraint record for resident #011, for the identified intervention, for a specified month, and stated that there was missing hourly documentation on an identified date; for specific shifts, on an identified date; for a specific shift, and on an identified date; for a specific shift.

Inspector #693 obtained a copy of the home's policy, titled, "Physical Restraints Monitoring, RC-22-01-03", last updated February 2017. The policy identified that care staff were to record safety checks completed every hour while the restraint was in use on the restraint record and that each shift the nurse was to review and sign the restraint record, and evaluate the continued need for the physical restraint.

The Administrator, reviewed the Restraint Record for the "identified intervention for resident #011 and confirmed that there was no hourly monitoring completed on an identified date; for specific shifts, on an identified date; for a specific shift, and on an identified date; for a specific shift.

b) Resident #011 was observed by Inspector #625 to have been utilizing two potential restraints.

Inspector #693 made further observations of resident #011 on identified dates. During these observations, resident #011 was observed to be utilizing two potential restraints. On each of these occasions, Inspector #693 asked resident #011 if they were able to release one of the identified potential restraints, and the resident was unable to perform the task.

Inspector #693 reviewed the most current care plan for resident #011, last updated on an identified date. The care plan identified that staff were to monitor resident #011 hourly, when utilizing an identified restraint and to have ensured that another identified restraint was fastened at all times when in the ambulation device; as well, the care plan, indicated that resident #011 sometimes leaned very forward in their ambulation device, to reach for something and that staff were to recline the ambulation device as needed.

During an interview with PSW #106, they stated resident #011 utilized an identified restraint when in their ambulation device and that it was a restraint as the resident was not able to release it; as well, that they utilized another identified restraint. Together with the Inspector, PSW #106 reviewed the Restraint Record for resident #011. The PSW stated that there was no monitoring completed for the use of either identified restraint by resident #011, and that there was no Restraint Record for either of these restraints.

During an Interview with RPN #110 they stated that resident #011 utilized an

identified device, and another identified device as restraints. RPN #110 stated that the use of this identified device was considered a restraint as the resident was not able to release it; as well, that resident #011 utilized another identified restraint as a restraint because the resident often leaned forward to reach, and so required the restraint to prevent them from falling out of the ambulation device. The RPN stated that in the "Restraints" section of resident #011's most current care plan, it identified that the identified restraint was a restraint, but not the other identified restraint. RPN #110 confirmed that no monitoring was being completed for the use of either of the identified restraints for resident #011.

During an interview with the Administrator, they stated that all restraints should be monitored and documented hourly by the PSWs and that the RPNs were to evaluate and document the need for the physical restraint by signing the Restraint Record. The Administrator acknowledged that there was no monitoring completed for either of resident #011's identified restraints. [s. 110. (2) 3.]

2. The licensee has failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: that the resident's condition was reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

a) Resident #011 was observed by Inspector #625 to have been in bed, with an intervention in place on their bed.

Inspector #693 made further observations of resident #011 on identified dates. During these observations, resident #011 was observed laying in their bed with an intervention in place on the bed.

Inspector #693 completed a review of resident #011's medical record. Resident #011's medical record contained a valid order from a physician for an identified restraint, as well as a signed consent form, from resident #011's SDM allowing the use of the identified restraint.

Inspector #693 reviewed resident #011's Restraint Record form, and identified that on several days during an identified month, there was no monitoring or evaluation of the restraint completed by a registered staff member.

During an Interview with RPN #111, they stated that the RPNs were responsible for monitoring and evaluating a resident's restraint every eight hours on each resident's Restraint Record form. RPN #111 stated that the registered staff who completed the eight hour monitoring and evaluation of the restraint were to sign the Restraint Record and if there was no signature then this would mean that the monitoring and evaluation was not completed. They stated that resident #011 utilized an identified restraint. RPN #111 reviewed the restraint record for resident #011, for the identified restraint, for an identified month, and stated that there was missing documentation for the monitoring and evaluation that was to be completed by the registered staff on identified dates and specific shifts.

Inspector #693 obtained a copy of the home's policy, titled, "Physical Restraints Monitoring, RC-22-01-03", last updated February 2017. The policy identified that care staff were to record safety checks completed every hour while the restraint was in use on the restraint record and that each shift the nurse was to review and sign the restraint record, and evaluate the continued need for the physical restraint.

The Administrator, reviewed the Restraint Record for the identified restraint for resident #011 and confirmed that there was missing documentation for the eight hour monitoring and evaluation that was to be completed by the registered staff on identified dates, and specific shifts. The Administrator stated that since there was no documentation on those days, they could not confirm if the monitoring and evaluation of the identified restraint for resident #011 had been done every eight hours on each of those shifts.

b) Resident #011 was observed by Inspector #625 to have been utilizing two potential restraints.

Inspector #693 made further observations of resident #011 on identified dates. During these observations, resident #011 was observed to be utilizing two potential restraints. On each of these occasions, Inspector #693 asked resident #011 to release an identified potential restraint, and the resident was unable to perform the task.

Inspector #693 reviewed the most current care plan for resident #011, last updated on an identified date. The care plan identified that staff were to monitor resident #011 hourly, when they utilized their ambulation device and to have

ensured that their potential restraint was engaged at all times when in their ambulation device.

Inspector #693 reviewed resident #011's Restraint Record form, and identified that there was no monitoring or evaluation of Resident #011's identified restraints, every eight hours, or at any time completed for an identified time period.

During an Interview with RPN #110 they stated that resident #011 utilized identified devices, as restraints. RPN #110 stated that the use of the identified restraint was considered a restraint as the resident was not able to undo it; as well the other identified restraint was considered a restraint as the resident often leaned forward to reach, and so required the restraint to prevent them from falling out of the ambulation device. RPN #110 confirmed that no monitoring or evaluation was being done every eight hours by a registered staff for either restraint, utilized by resident #011.

During an interview with the Administrator, they stated that all restraints should be monitored and documented hourly by the PSWs and that the RPNs were to evaluate and document the need for the physical restraint by signing the Restraint Record. The Administrator acknowledged that there was no monitoring or evaluation completed for resident #011's utilization of the seatbelt or tilt chair. [s. 110. (2) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: that the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose; and that the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Inspector #625 reviewed a safety report from an identified date , which identified resident #024 had been ordered a specific medication, for an identified period of time and, as per the order, the most responsible physician was to reassess the dosing prior to stopping the medication. The order was auto-stopped on the eMAR on an identified date; however, the resident's medication roll continued to have the identified medication present and the resident received the medication without a current order during a specified period of time.

Inspector #625 reviewed resident #024's health care record including a Medication Reconciliation Order Form New Admission from another facility, from an identified date. The form identified the resident was ordered the identified medication at a specified dose for a specific period of time, stopping on an identified date. The form also noted that the medication was to be reassessed in an identified month, prior to stopping to determine if further tapering was needed.

During an interview with the Best Practice RN, they acknowledged that resident #024 did not have the identified medication reassessed in an identified month and the resident continued to receive the identified medication, despite the reassessment being required prior to continuing to receive it.

During an interview with Pharmacist #148, they stated that the resident had been provided with the identified medication beyond the date of the ordered reassessment, without a doctor's order, as it would have been detrimental to the resident to stop the medication abruptly, but that the home should have contacted a physician to obtain a valid order. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During observations of resident rooms, the following areas of disrepair were noted:
- shared washroom in an identified resident room, the safety bar on the left side of the toilet was not attached to toilet and detached when moved;
- shared washroom in an identified resident room, the toilet paper holder missing roll holder bar; and
- shared washroom in an identified resident room, the toilet paper holder missing paper holder bar.

During an interview with the Lead Hand of Maintenance, they reported to Inspector #196 that PSW or nursing staff were to fill out a mechanical work order, provide this to the ward clerk, who would then enter this into the computer, and the task would get assigned with a priority number for repair.

The Lead Hand of Maintenance, together with the Inspector, observed resident shared washrooms in identified rooms, and confirmed that there was no roll to put the toilet paper roll on, and observed the safety bar on the left side of the toilet was not attached to the toilet and detached when moved, and acknowledged these areas of disrepair.

During an interview with PSW #150, they reported to the Inspector that they would submit a work order for maintenance when something was not working properly.

On an identified date, the Lead Hand of Maintenance, confirmed to the Inspector that no work orders had been submitted for the areas identified. They then provided copies of work orders they had prepared for an identified resident room washroom, "please repair/replace toilet grab bar assembly" and "Please patch and repair drywall in corner by toilet" and "Please ensure all patient room washrooms have a toilet paper holder" for 2nd floor and also for 3rd floors. [s. 15. (2) (c)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received individualized personal care, including hygiene care and grooming, on a daily basis.

During resident observations, on identified dates, Inspector #625 observed resident #009's fingernails to be unclean. On an identified date, the Inspector noted a black substance under the fingernail of the fifth digit of the resident's left hand and the second digit of their right hand. On another identified date, the Inspector again observed black debris under the fingernail of the second digit of the right hand.

During subsequent observations of resident #009 on an identified date, the Inspector observed the resident's hands covered with a red sticky substance, a clump of the red substance covered one nail and was smeared on multiple other nails, the palms and backs of both hands. The black debris noted underneath the resident's second digit fingernail of their right hand was again observed.

On an identified date, at a specific time, the Inspector noted black debris under the third digit fingernail of their left hand, and under the second and third digit fingernails of their right hand. At a specified time, the Inspector again noted black debris under the resident's fingernails.

A review of the resident's current care plan, effective an identified date, indicated the resident required an specified level of assistance from staff with personal hygiene.

During an interview with PSW #151 on an identified date, the PSW confirmed the resident had black debris underneath their fingernails.

During an interview with PSW #121, they acknowledged the debris under resident #009's fingernails was present, including black debris underneath the finger nail of the right hand second digit, and a brown substance underneath several other nails on both hands. The PSW soaked the resident's hands in a basin and cut their nails, removing the black debris. The PSW stated that they believed the debris to be from food. The PSW stated staff were required to provide all hygiene and grooming care to resident #009 which included cutting and cleanliness of their fingernails.

During an interview with RPN #125, they stated that residents were supposed to receive hygiene and grooming care on a daily basis, including nail care. The RPN acknowledged that resident #009 should have had the black debris, or old food, removed from underneath their nails daily by staff as needed. The RPN also acknowledged that the red substance on the resident's hands should have been cleaned and should not have remained from one meal to the next. [s. 32.]

WN #21: 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.

During a staff interview, with the Best Practice RN, it was identified that resident #012 had experienced an incident on an identified date, where they fell from their bed onto a falls mat, and had not sustained an injury.

Inspector #693 reviewed the progress notes, electronically for resident #012. The e-note from an identified date, composed by RPN #119 indicated that resident #012 had experienced an unwitnessed accidental identified incident and a PSW found resident #012 lying down, on the falls mat beside their bed and resident #012 stated that they slid off their bed onto the floor. The e-note indicated that resident #012 did not exhibit signs of injury.

Inspector #693 reviewed resident #012's medical record, and identified a document entitled "Post-Fall Assessment Tool". The document indicated that the date of the fall was an identified date, but was not completed in entirety and the back of the tool was left blank. The tool and did not identify the resident's name, the date of report, whether or not a post fall huddle was completed, main root cause, how the fall may have been prevented, follow-up plan or recommendations, medications that were administered in the last 12 hours leading up to the fall, fall prevention interventions, and the signature of the person who completed the "Post-Fall Assessment Tool."

During an interview with RPN #116, they stated that when a resident falls, the RPN or RN was responsible for completing the post-fall assessment tool. Together with the Inspector, RPN #116 reviewed the "Post-Fall Assessment Tool" for resident #012, from the February 24, 2019 fall. RPN #116 stated that the form was not fully completed and that most vital information was left blank, including the resident's name, date of report, name of staff who completed the report, and if a post falls huddle was completed.

Inspector #693, obtained a copy of the home's policy, titled, "Fall Prevention and Management Program, RC-15-0101", last updated February 2017. The policy indicated that when a resident fell, a registered staff member was to complete the "Post-Fall Assessment Tool" as soon as possible. The policy included an appendix, titled "Appendix 11- Post-Fall Assessment Tool" that identified how staff were to have completed the tool.

During an interview with the Administrator, they reviewed the "Post-Fall Assessment Tool", for resident #012, from the incident on a specified date. The Administrator stated that the staff had not fully completed the tool, as was

required. [s. 49. (2)]

WN #22: 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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident #008 was identified as having normal functioning of a bodily process and as needing an assistive device to complete the same bodily process, as per their Resident Assessment Instrument - Minimum Data Set (RAI-MDS) quarterly review, dated with an identified date.

During the inspection, Inspector #625 reviewed resident #008's health care record including assessments with identified titles from identified dates, each of which identified the resident used an assistive device to complete a bodily process.

The Inspector also reviewed an Order Sheet and Progress Notes documented on

a specified date, which identified the resident's specific assistive device was ordered to be removed, and was removed on that date.

(a) A review of the licensee's "Continence Care and Bowel Management Toolkit – Long-Term Care", dated May 2016, identified that the registered nursing staff were to conduct a bladder and bowel continence assessment, located in Appendix A, following a change in condition that may affect bladder or bowel continence.

The Inspector was not able to locate any continence assessments, electronic or hardcopy, that identified that resident #008 no longer used the identified assistive device, and was not able to locate a completed identified assessment, referred to in Appendix A.

During interviews with resident #008, they stated that they had their identified assistive device was removed a couple of days earlier and required staff assistance to manage their identified activity of daily living (ADL).

During an interview with PSW #120, they stated that resident #008's assistive device was removed two days earlier and the resident would let the staff know if they needed assistance with the identified ADL.

During an interview with the RAI Coordinator, they stated that resident #008 should have had an identified assessment completed as a result of the removal of their assistive device, but the RAI Coordinator checked the resident's health care record and one had not been completed. The RAI Coordinator also stated that the home did not complete the identified assessment referred to in the home's program, but completed electronic assessments.

During an interview with the Best Practice RN, they stated that resident #008 had an identified assistive device on admission and was now of an identified level of functioning for a specified ADL and was on an identified schedule to complete this ADL. The Best Practice RN indicated that it would be appropriate for staff to complete an identified assessment as the resident had experienced a change in their identified ADL status. The Best Practice RN was not able to locate an identified assessment completed for the resident after the removal of their identified assistive device.

During an interview with the DOC, they acknowledged that resident #008 should

have had an identified assessment completed after the resident's assistive device had been removed as it was a change in condition which affected the resident's identified ADL functioning, as per the home's identified program.

(b) A review of the licensee's "Continence Care and Bowel Management Toolkit – Long-Term Care", dated, May 2016, identified that the registered nursing staff were to initiate a three day voiding assessment, referred to in Appendix B, that included fluid intake, urine voided, and incontinence episodes to establish the resident's individual voiding pattern and trends. The record was to be completed on admission and as required.

Inspector #625 was not able to locate an identified record for resident #008 initiated or completed after the removal of their assistive device.

During an interview with PSW #121, an identified number of days after resident #008's identified assistive device had been removed, they were unable to locate a specific record initiated or completed following the removal of the resident's identified assistive device.

During an interview with the Best Practice RN, they stated that resident #008 should have had an identified record initiated as the resident had experienced a change in their specified ADL status.

During an interview with the DOC, they acknowledged that an identified assessment for a specified number of days should have been completed, as required in the home's identified care program, as now the resident's specific ADL status had changed. [s. 51. (2) (a)]

WN #23: 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 if the Residents' Council had advised the licensee of concerns or recommendations, the licensee within ten days of receiving the advice, responded to Residents' Council in writing.

During an interview with Inspector #542, the President of the Residents' Council, resident #007, indicated that they did not hear back from management in writing within ten days regarding concerns. They further stated that management would respond verbally, directly to the person that raised the question or the concern and then they would discuss it further at the next Resident Council meeting.

Inspector #542 interviewed the Resident Council's Assistant, Resident Counselor #102. They indicated that they typically responded individually to the person that had the question and not to the whole council.

Inspector #542 reviewed copies of the Residents' Council meeting minutes from an identified date, and noted that a resident had asked about the Christmas dinner. At the bottom of the minutes it was documented that another staff member followed up with the resident that raised the question. There was not a written response to the Resident Council.

Inspector #542 interviewed the Administrator, who confirmed that the home had not been responding to the Resident Council in writing and that it was their expectation that this was being completed. [s. 57. (2)]

WN #24: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that within 10 days of receiving the advice, responded to the Family Council in writing.

Inspector #542 conducted an interview with the President of the Family Council. The President indicated that the home had not responded to the Family Council within 10 days of receiving advice, in writing.

Inspector #542 reviewed the Family Council meeting minutes from, an identified month, and noted that a suggestion was raised regarding residents' hearing aids. At the bottom of the minutes it was documented that the assistant to the council would inquire about a hearing aid clinic.

Inspector #542 interviewed the assistant to the Family Council who indicated that they did not respond in writing to the Family Council. They further indicated that they would follow up with the individual that raised the question or concern and not the whole Family Council.

Inspector #542 interviewed the Administrator who indicated that it was their expectation that the home respond within 10 days, in writing to the Family Council. [s. 60. (2)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to, as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, ensure that procedures were developed and implemented for, cleaning of the home, including, common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

a)On an identified date, during observations of the second floor common dining room, a wall surface had dry food debris present.

During an interview with Housekeeping Aide #152, they reported to the Inspector that both the dietary aides and housekeeping staff would address any areas on dining room walls that needed wiping.

During an interview with the ESS, they confirmed to the Inspector the presence of food debris and soiling of the wall surface in the common dining room. They further reported that this area needed to be cleaned.

b)During observations conducted by Inspector #196, there were two black plastic dining carts positioned beside the servery counter, that were soiled on the surface and handles with dry spills, crumbs and debris. Continued observations of the third floor dining room identified three black plastic dining carts positioned beside the servery counter, soiled on the surface and handles with dry spills, crumbs and debris.

During interviews with DA #153 And DA #130, they reported the PSWs used the dining carts for delivering tray service to the residents in their room, or for beverage service or to bring food up from the kitchen. In an interview with PSW #114, they reported the carts were also used to deliver the soup during lunch to the resident's seated in the dining room.

During an interview with the FSS, they acknowledged that these dining carts were unclean, not hygienic and had told the staff to clean the carts.

During an interview, the Administrator acknowledged that the dining carts as observed on the second floor dining room, had dry food debris, dry spills, and food crumbs and should have been cleaned. [s. 87. (2) (a) (ii)]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

(a) Inspector #625 reviewed a safety report for a medication incident from an identified date, for resident #024. The report identified that the resident had been ordered an identified medication for a specific time period, at which time the resident's most responsible physician was to reassess the dose before stopping the medication. The order was auto-stopped on the eMAR on an identified date, but the medication was still present in the resident's medication roll without an active order, which resulted in the resident receiving the identified medication without an order for a specific period of time.

Inspector #625 reviewed resident #024's progress notes and identified two entries related to the medication incidents, both dated an identified date, neither of which indicated the resident or their SDM had been notified of the medication incident.

During an interview with resident #024, they stated they had not been informed of the medication error discovered on an identified date, prior to speaking with the Inspector.

During an interview with resident #024's SDM, they stated that they had not been informed by the home of the medication error discovered on December 25, 2018, and had learned of it when contacted by the Inspector.

During an interview with the Best Practice RN, they stated they could not recall if they had informed the resident or SDM of the medication error. The Best Practice RN reviewed the progress notes and acknowledged that there was no record that could establish if either the resident or their SDM had been notified of the medication incident.

During an interview with the Administrator, they were unable to locate a progress note that identified the resident or their SDM were notified of the medication incident. They stated that the resident should have been notified of the medication incident.

(b) Inspector #625 reviewed a safety report for a medication incident from an identified date, for resident #028. The report identified the resident was administered an identified dose of a specific medication, after it was discontinued on an identified date. The report did not identify that the resident or their SDM were notified of the incident.

Inspector #625 reviewed resident #028's progress notes and was not able to locate a progress note that identified the resident or their SDM were notified of the medication incident.

During an interview with resident #028, they stated their SDM would be the person who would be informed of any medication incidents involving the resident.

During an interview with resident #028's SDM, they stated that they had not been informed of the medication incident that occurred in an identified month, involving the resident receiving an identified dose of a specific medication after it had been discontinued.

During an interview with the DOC, they stated that residents or their SDMs were

to be notified of all medication incidents or adverse drug reactions. [s. 135. (1)]

Issued on this 10th day of July, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by RYAN GOODMURPHY (638) - (A2)
Inspection No. / No de l'inspection :	2019_768693_0005 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	004151-19 (A2)
Type of Inspection / Genre d'inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 10, 2019(A2)
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, 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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 20. of the LTCHA. Specifically, the licensee must:

a) Ensure residents #001, #002, #004, #018, and #019, and all other residents, are protected from abuse and neglect by staff.

b) Ensure all staff review the home's policy entitled "Zero Tolerance of Resident Abuse and Neglect Program - RC-02-01- 01", specifically but not limited to the area of reporting abuse and neglect. This process should be documented to include; the dates of the review, the names and classifications of the staff who completed the review, the content of the review, and any other pertinent documents.

Grounds / Motifs :

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

a) A Critical Incident System (CIS) report was submitted to the Director on an identified date, where it was alleged that PSW #104 was negligent towards residents #001, #002, and #003. It was documented in the report that all three residents were not provided with a specified meal.

Neglect is defined within the Ontario Regulation 79/10, as the failure to provide a

resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Inspector #542 reviewed the home's investigation file, which indicated that PSW #104 was negligent towards residents #001, #002, and #003 by failing to provide them with a specified meal. It was also documented that resident #001 had an identified medical diagnosis and had not received a specified meal or nourishment. Resident #002 was not provided with a specified meal, was left in bed all day and required a certain number of staff for assistance with care, none of which was provided as per their care plan. Resident #003 was not provided with a specific meal or nourishment and did not receive an intervention as per their care plan.

Inspector #542 interviewed the Administrator who indicated that PSW #104 was found to be negligent towards all three residents. The Administrator further indicated that PSW #104 was found to be negligent in a specific month during a specific year, towards two different residents which resulted in a suspension. The Administrator provided two additional CIS reports that were submitted to the Director on a specified date.

Inspector #542 reviewed the two CIS reports that were submitted on a specified date, for neglect. It was documented that resident #018 was provided with care at an identified time and not again until a later identified time. Resident #018 was found to be incontinent, having both their clothing and ambulation device soiled. The second CIS report indicated that resident #019 was not provided with specified care needs. A PSW reported to PSW #104 that resident #019 was incontinent at an approximate time. At a specified time, resident #019 remained to be incontinent, and it was noted that they were not provided with assistance until a later time. PSW #104 was the primary caregiver for resident #018 and #019.

The home completed their investigation which concluded that PSW #104 was negligent towards both residents.

b) A CIS report was submitted to the Director on an identified date, that outlined alleged neglect. It was documented in the CIS report that resident #006 was not provided with care during a specific shift. Resident #006 was found in the morning, with evidence of care not being provided.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Inspector #542 reviewed the home's investigation file that was provided by the Administrator. It was documented that the incident occurred on a specified date; however, the staff failed to report the incident to anyone until an identified number of days later.

Inspector #542 interviewed the Administrator who acknowledged that the staff did not report the neglect until an identified number of days later.

A review of the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program – RC-02-01- 01" last updated, April 2017, identified neglect as the failure to provide a resident with the treatment, care, services or assistance, required for health, safety or well-being, and included inaction or pattern of inaction that jeopardized the health, safety or well-being of one or more residents. Furthermore, it was documented in the policy that, when any employee or person who became aware of an alleged, suspected or witnessed resident incident of abuse or neglect, they were to immediately report the incident to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at the time. [s. 20. (1)]

The decision to issue a Compliance Order (CO) was based on the severity which indicated the potential for actual harm to occur, and the scope, which indicated that there was a pattern of non-compliance. In addition, the home's compliance history identified a history of non-compliance specific to this area of the legislation, as follows:
- a Voluntary Plan of Correction (VPC) was issued from a Resident Quality Inspection (RQI) #2018_703625_0001, on March 26, 2018;
- a VPC was issued from a RQI #2017_463616_0007, on August 2, 2018; and
- a VPC was issued from a RQI #2016_333577_0012, on October 24, 2016. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 22, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be in compliance with s. 6. (7) of the LTCHA. Specifically the licensee must:

a) Conduct and document scheduled audits of residents' plans of care to ensure they are providing care as specified in each residents' plans of care.

b) Ensure resident #013 and #023's plans of care are followed specifically, but not limited to their diet and beverage texture.

c) Ensure resident #010's plan of care is followed specifically, but not limited to their utilization of identified interventions.

d) Ensure all residents' plans of care are followed specifically, but not limited to areas related to the physician's identified treatment orders.

e) Maintain a record of the actions taken to address the above items.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #625 observed specific texture meal items in front of resident #023 during dining room observations on identified dates.

During interviews with Inspector #625, on identified dates, resident #023 stated they had been provided with a specific diet when they had been assessed as able to have a different specific diet. The resident stated they did not want this specific texture meal and did not ask for it.

A review of resident #023's health care record included a SLP recommendation, dated, an identified date, that recommended a trial to upgrade the resident's diet to a specific texture diet. The next entry, dated another identified date, and written by the RN (EC) ordered staff to implement the Speech Pathologist recommendations.

Inspector #625 reviewed the Resident Diet Census dated, an identified date, which identified resident #023 was ordered a specific texture diet.

During an interview with PSW #106, they stated that staff were required to ask for resident meals by name and a mistake had been made when the resident was provided with a specific texture meal on an identified date. The PSW stated, resident #023 should have been provided with a different specific diet texture.

During an interview with the FSS, they stated that they had updated the Resident Diet Census sheet on an identified date, to include the SLP diet recommendations [including a specific texture diet]. [s. 6. (7)] (625)

2. On an identified date, resident #013 was observed with a specific beverage on the table in front of them. During the observations, PSW #131 reported that the resident had a specific texture beverage and demonstrated the texture as the beverage dripped off of the spoon.

The Inspector along with PSW #131, reviewed the servery list dated, a specific date, which indicated "a specific texture of fluids were to be provided to resident #013. PSW #131 then reported that they had provided a specific texture beverage to resident #013 and upon reading the servery list, confirmed that the incorrect texture of beverage had been provided to the resident. DA #132 proceeded to spoon the accurate specific texture beverage for resident #013.

The health care records for resident #013 were reviewed. The most recent Physician Orders identified an ordered, specific beverage texture and identified medical condition. The current care plan indicated under an identified focus, a specific beverage texture, and under other identified foci noted a different specific beverage texture.

During an interview with the DOC, together with Inspector #196 they reviewed the current care plan for resident #013. The DOC confirmed that care was not provided to the resident as specified and that in two areas of the care plan, different specific texture beverages were listed. [s. 6. (7)] (196)

3. On identified dates, Inspector #196 observed an intervention in place on resident #010's bed.

The health care records of resident #010 were reviewed. The current care plan indicated the resident was a specific level with transferring and bed mobility. The most recent quarterly MDS assessment did not indicate the use of the observed intervention on their bed, and the, "Bed Safety Analysis" dated, an identified date, identified no risk, no specific intervention, and that the resident was a specific level with bed mobility.

During an interview with resident #010, when questioned by the Inspector whether they used the identified intervention on their bed, they reported they did not use the intervention and "they just have them like that".

During an interview with RPN #119, they confirmed to the Inspector, that the identified intervention was in place, on resident #010's bed. The RPN further reported, after a review of the "Bed Rail Safety Analysis", that the intervention should not have been used according to the analysis.

During interviews with the Administrator, they stated that the beds came with the identified intervention, the intervention could be lowered and not used. The Administrator confirmed that the identified intervention was not to be used, as per the analysis. [s. 6. (7)] (196)

4. A written complaint was submitted to the Director regarding resident #017's wound care treatment, weight loss and health decline since admission to the home on an identified date.

Refer to WN #2, finding #6 for further details.

The licensee's skin and wound program titled "Wound Care Management – February 2017 – RC-23-01-02", read, "Document all skin breakdown in the interdisciplinary progress notes (or wound progress note) and in surveillance tools".

The health care records for resident #017 were reviewed for information regarding the provision of an area of altered skin integrity. The care plan included an intervention ordered by an MD for the area of altered skin integrity. A "Wound Assessment Tool" was initiated on an identified date, for an area of altered skin

integrity. The Physician's Orders dated, an identified date, indicated an intervention to be completed. The "Wound Assessment Tool" for an identified month, did not have documented specific interventions and treatments on multiple specified dates.

During an interview with the Best Practice RN, they reported to the Inspector that the registered staff would fill out the "Wound Assessment Tool" every time the treatment was completed. They further reported this tool also served as the weekly wound assessment.

During an interview with the DOC, they confirmed to the Inspector, upon review of the "Wound Assessment Tool", that the physician ordered treatments were not documented as completed on numerous identified dates. They further reported if the treatment was "not charted, it was not done". [s. 6. (7)]

The decision to issue a Compliance Order (CO) was based on the severity which indicated the potential for actual harm to occur, and the scope, which indicated that there was a pattern of non-compliance. In addition, the home's compliance history identified a history of non-compliance specific to this area of the legislation, as follows:
- a VPC was issued from a Critical Incident System (CIS) Inspection #2019_703625_0003, on February 8, 2019;
- a VPC was issued from a Follow Up (FU) Inspection # 2018_616542_0015, on September 24, 2018;
- a VPC was issued from a Resident Quality Inspection (RQI) #2018_703625_0001, on March 26, 2018; and
- VPC was issued from a Complaint Inspection #2017_435621_0005, on February 14, 2017. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 22, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or a medication cart,

(i) that is used exclusively for drugs and drug-related supplies,

(ii) that is secure and locked,

(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and

(iv) that complies with manufacturer's instructions for the storage of the drugs; and

(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

The licensee must be compliant with s. 129. (1) (a) (ii) of Ontario Regulation 79/10.The licensee shall ensure that drugs are stored in an area or a medication cart that is secure and locked. Specifically the licensee must:

a) Ensure that medicated topical treatments, and all drugs are kept secured and locked.

b) Conduct an audit of medicated topical treatments kept unsecured at residents' bedsides and in their bathrooms, including in the rooms of resident #008, #011, and #026. Ensure the medicated topical treatments, or any other drugs found at the bedside, or in bathrooms are stored and used as per the requirements identified in O. Reg. 79/10, s. 129. and s. 131. (1), (5), (6), and (7).

c)Establish a routine auditing schedule to address drugs stored at bedsides and in resident bathrooms, to ensure compliance with applicable legislation.

d) Maintain a record of the actions taken to address the above items.

Grounds / Motifs :

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

Ontario Regulation 79/10, s. 1, defines "topical" to mean a drug in the form of a liquid, cream, gel, lotion, ointment, spray or powder that is applied to an area of the skin and is intended to affect only the local area to which it is applied.

On an identified date, Inspector #625 observed a specified topical medication, in its original box which displayed resident #026's surname written in black ink, located in the shared resident washroom for an identified room.

On an identified date, the Inspector observed an unlabelled specified topical medication located in the shared resident washroom for an identified room.

On an identified date, the Inspector again observed the specified topical medications, in the shared washrooms of identified rooms.

The Inspector reviewed an order for an identified topical medication, dated, a specific date, for resident #008, who resided in an identified room, and an order for another identified topical medication, dated, a specific date, for resident #026, who resided in an identified room.

During an interview with the the Best Practice RN, they reviewed residents #008 and #026's charts and acknowledged the orders, as reviewed by the Inspector. The Best Practice RN then attended the shared washrooms for the identified rooms, and observed the identified topical medications to be unsecured, as previously identified by the Inspector. The Best Practice RN stated that the topical drugs should not have been kept in the unsecured shared resident bathrooms which were accessible to anyone.

During an interview with the DOC, they acknowledged that topical drugs, including the specified medications, should have been kept in an area where they were secured and locked, as per legislative requirements. [s. 129. (1) (a) (ii)] (625)

2. 2. During observations of resident #011 on an identified date, Inspector #196 noted an identified number of prescription labelled topical medication on the bedside table.

During an interview with PSW #135, they reported that the identified topical medication should not have been kept on the bedside table.

During an interview with PSW #114, they reported that prescription medications were to be stored in the locked resident carts.

A review of the pharmacy provider's (Janzen's) policy re: "Medication Storage in the Facility", revised September 2018, indicated, "Medications are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier, and in accordance with federal and provincial laws and regulations. The medication supply is accessible only to authorized personnel."

During an interview with the DOC, they reported that topical prescription medications, creams, were to be kept and stored securely, locked in resident care cart or in medication room, or in the medication cart and were not to be kept at a resident's bedside. [s. 129. (1) (a) (ii)]

The decision to issue a Compliance Order (CO) was based on the home's ongoing non-compliance with this section of the legislation, the severity was minimal harm or potential for actual harm, and the scope was a pattern. The home has a history of non-compliance in this area of the legislation as follows:
- a Compliance Order was issued from a Resident Quality Inspection (RQI) #2018_703625_0001, on March 26, 2018;
- a Compliance Order was issued from a RQI #2017_463616_0007, on August 2, 2018; and
- a Voluntary Plan of Correction (VPC) was issued from a RQI #2016_333577_0012, on October 24, 2016. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 22, 2019

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(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).

Order / Ordre :

The licensee must be compliant with s.15. (1) (a) of O. Reg. 79/10. Specifically, the licensee must:

a) Re-evaluate all bed systems in the home using the weighted cone and cylinder tool in accordance with "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008.Specifically, the bed systems are to be evaluated for zones 2, 3, and 4, and for beds with rotating assist rails, the bed rails are to be evaluated in both the transfer (vertical position) and in the guard (horizontal) position.

b) Where one or more bed rails will be applied or attached to a bed frame, equip the bed frame with mattress keepers that will keep the mattress from sliding side to side, and will allow the mattress to fit properly between the keepers (mattresses must not sit on top of the keepers).

c) Where bed rails do not pass zone 2, 3, or 4, mitigate the bed system in accordance with "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" or equip the bed systems with a different manufacturer's compatible bed mattress or bed rail that passes zones 1 to 4.

d) Inspect each bed when conducting bed system evaluations for condition as per the manufacturer's recommendations (castor brakes, remote, manual cranks, head and foot board condition, mattress condition, bed rail condition).

e) Educate all bed system evaluators on the requirements of the Health Canada guidelines entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, March 2008" and "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment". (U.S. FDA June 21, 2006).

f) Make available the results of the bed system re-evaluation to the interdisciplinary team who participates in assessing each resident for bed rail safety.

g) Keep accurate and detailed records as to the zones that were tested, what has been done to a bed once it is initially evaluated (i.e. what specific change was made to the bed, the date the change was made, bed and mattress identifier, who made the changes, the re-evaluation date, auditor name and results).

h) Amend or update policy LT 5-80 entitled "BED SAFETY-PREVENTION OF ENTRAPMENT" to include a "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment". (U.S. FDA June 21, 2006) and any additional information and guidance for bed system evaluators for a thorough evaluation.

i) Maintain a record of the actions taken to address the above items.

Grounds / Motifs :

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

During resident observations, Inspector #625 observed an intervention in place on resident #008's bed.

During interviews with Inspector #625, PSWs #120, #133 and #136, stated that resident #008 used the identified intervention when in bed; this was also confirmed by resident #008.

On August 21, 2012, a notice was issued to the Long Term Care Home (LTC) Administrators from the Director of the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, identifying a document produced by Health Canada entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was expected to be used as the best practice document in LTC Homes and provides clear procedures and dimensional criteria with respect to evaluating bed systems using a cone and cylinder tool. The Health Canada Guidance (HCG) document also includes the title of a companion guide developed by the Food and Drug Administration (FDA) in the United States entitled “Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006”. The guide includes information with respect to the various options and corrective strategies available to mitigate entrapment zones, a guide to buying beds, how to inventory bed systems and reviews the dimensional criteria of bed systems. The documents are considered prevailing practices, which are predominant, generally accepted widespread practice as the basis for clinical decisions with respect to bed safety.

The home’s policy titled, “BED SAFETY – PREVENTION OF ENTRAPMENT – LTC 5-80”, approved June 2016, identified that each resident and his/her bed must have been assessed individually for entrapment risks, and interventions intended to reduce the risk of entrapment should have been tailored to meet each individual’s needs. The policy identified that all residents should have an individualized Bed Safety Analysis completed. The policy also identified that a second document, a Bed Rail Safety Analysis, was to be completed on admission; whenever a Bed Safety Analysis was performed; whenever a resident changed his/her mattress, bed fame, or any other bed-related products; and whenever a staff member felt it was necessary for resident safety.

Resident #008’s MED e-care information identified that the resident was admitted to the home on an identified date, into a specified room, and then transferred to a different room on an identified date.

Inspector #625 reviewed documents titled Bed Safety Analysis and Bed Rail Safety Analysis, both dated an identified date, and both of which identified that the bed used by resident #008 in room an identified room had no entrapment zones failed.

During an interview with the Best Practice RN, they stated that they had completed both the Bed Safety Analysis and Bed Rails Safety Analysis documents dated an identified date, for resident #008 when they had resided in an identified room. The Best Practice RN indicated that they did not know which type of bed or which specific bed they had assessed, or if the resident was still using the same bed or not. The Best Practice RN stated their notation that there had been no entrapment zones failures was based on their visual estimation if a hand or leg could get wedged in the different areas of the bed. The Best Practice RN indicated that they had not received any special training on assessment of the bed systems or entrapment zones.

During an interview with the Coordinator Client Safety & Risk, they stated that they had completed entrapment zone testing with OT #138 in the past but, more recently, had conducted a visual inspection [which did not include testing of entrapment zones] of bed systems, in January 2018. The Coordinator referred to a table provided to the Inspector titled, "Bethammi Nursing Home Assessment of Beds – January 2018". The Coordinator stated they had not retained original testing documents used to record the results of the earlier entrapment zone testing completed with the bed system measurement device.

Inspector #625 reviewed the table titled, "Bethammi Nursing Home Assessment of Beds – January 2018", and noted the concerns recorded included:
- the footboard for one bed appeared to be a headboard installed on an angle;
- mattress keepers were not engaged on multiple beds;
- mattresses were sitting outside of mattress keepers on multiple beds;
- mattress keepers were missing;
- mattresses were too short for multiple beds;
- long comforters tucked under mattresses elevated the mattress out of the keepers on multiple beds;
- fitted sheets were too tight for multiple mattresses causing them to curl up and shorten;
- mattresses were reversed on multiple beds;
- multiple mattresses required replacement as they were in poor condition;
- a low air loss mattress was not securely attached to a bed; and

- one bed was mislabelled as a Stryker FL 13 when it was a Joerns Hi-Low bed.

The table also identified that Bed Safety Analysis documents could not be located for 13 bed systems, one did not contain the year the assessment was completed and another was undated and unsigned. The table also identified that one of the mattresses could not be visually assessed as the resident was sleeping at the time.

The table identified that full bed rails were used for five residents, and that, for all five of those bed systems, Bed Safety Analysis documents should have been repeated due to discrepancies between the use of full rails and those listed on the most recent Bed Safety Analysis; the reasons for full rail use was not clearly documented; entrapment prevention equipment was needed if residents were considered at risk for entrapment; a bed system using a low air loss mattress and full rails had no Bed Safety Analysis located on the chart.

The table also identified numerous Bed Safety Analysis that were incomplete, not dated, contained information that was different than that observed. In total, the table recommended the home complete 13 Bed Safety Analysis documents; repeat 26 Bed Safety Analysis documents, and repeat an additional 12 Bed Safety Analysis documents, if criteria had changed.

Furthermore, one entry identified the Bed Safety Analysis had been completed in January 2018, but that the mattress had since changed and the completion of the analysis should have been repeated. A second entry identified the Bed Safety Analysis had been completed on January 27, 2018, and the overlay had been completely deflated and the mattress was cracked and required replacement. Despite the Bed Safety Analysis documents being completed either the same month, or the previous month, neither had reflected accurate or current analysis for the residents' bed systems.

The Inspector noted that two of the entries, identified the bed type as Invacare CS7, with a mattress type of GeoMatt 80", and full bed rails. One had a Bed Safety Analysis dated, November 17, 2017, that identified the resident used two bed rails, not full bed rails; and another dated December 12, 2017, identified that entrapment prevention equipment may be required and the Bed Safety Analysis (completed the previous month) should have been repeated.

A review of a document titled, "CS7 bed assessment – 80" Geo Matt with full rail", dated February 2, 2017, and provided by the home identified that entrapment zones 4 and 6 were a risk at the head of the bed with the full bed rails in use. The document recommended eliminating the use of full rails.

During an interview with the Project Manager, they stated that the home had ordered 22 new beds in October of 2018, and that none of the 22 beds had been tested for bed entrapment.

During interviews with the Administrator, they stated that nursing staff completed entrapment zone testing although they did not have any specialized training to do so, and did not use a bed system entrapment tool to assess the beds. The Administrator also stated that one prototype bed [of the CS7 bed] had been tested for entrapment zones, not all of the beds in the home. [s. 15. (1) (a)]

The decision to issue a Compliance Order (CO) was based on the home's ongoing non-compliance with this section of the legislation, the severity was minimal harm or potential for actual harm, and the scope was a pattern. The home has a history of non-compliance in this area of the legislation as follows:
- a Compliance Order was issued from a Resident Quality Inspection (RQI) #2016_333577_0012, on October 24, 2016. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 22, 2019(A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 134. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Order / Ordre :

The licensee must be in compliance with s. 134. of O. Reg. 79/10. Specifically the licensee must:

a) Ensure that resident #008, and #013 are being monitored to determine the response and effectiveness of their as needed medication.

b) Conduct routinely scheduled audits of residents' electronic medication administration records and "Follow-Up Notes" to ensure that staff are monitoring the effectiveness of as needed pain medication. This process should be documented.

c) Maintain a record of the actions taken to address the above items.

Grounds / Motifs :

1. The licensee has failed to ensure that, when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and

documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Resident #008 was identified as having an identified level of pain as per their Resident Assessment Instrument - Minimum Data Set (RAI-MDS) quarterly review dated, an identified date.

Inspector #625 reviewed the home's toolkit titled, "Pain Management Toolkit Long-Term Care Bethammi Nursing Home", dated May 2016, which identified registered nursing staff were to document the effectiveness of the interventions in the eMAR with written follow-up in the e-notes.

A review of the resident's current care plan effective on an specified date, identified the resident had pain in an area of their body and that staff were to administer medications as ordered and assess the effectiveness of the medications given.

A review of analgesic medication ordered for resident #008 identified orders for a specified pro re nata (PRN) medication, and for another specified medication when required.

Inspector #625 reviewed resident #008's eMAR and noted that the two specified PRN medications had been administered, multiple times in an identified month.

A review of the PRN History report for resident #008 for a specified month, identified that a specific PRN medication was administered an identified number of times for pain, and another PRN medication was administered an identified number of times for pain. The corresponding Follow-Up Notes report identified that 91 per cent, of the first identified PRN pain medication; and 100 per cent, of the second PRN pain medication administration entries did not have corresponding follow-up notes regarding the effectiveness of the medications recorded on the eMAR. A review of the resident's electronic notes identified no documentation of the effectiveness of the identified PRN pain medications administered in a specified month.

A review of the PRN History report for resident #008 for an identified month, identified a specified PRN medication was administered a specified number of times for pain, and another specified PRN medication was administered a specified number of times for pain. The corresponding Follow-Up Notes report identified 100

per cent, of the first specified PRN medication; and 92 per cent, of the second PRN medication administration entries did not have corresponding follow-up notes regarding the effectiveness of the medications recorded on the eMAR. A review of the resident's electronic notes identified no documentation of the effectiveness of the PRN pain medications administered in a specified month, excluding the one note on the effectiveness previously identified in the specified month.

A review of the PRN History report for resident #008 from a specified time period, identified a specified PRN medication was administered a specified number of times for pain, and another specified PRN medication was administered a specified number of times for pain. The corresponding Follow-Up Notes report identified 100 per cent, of the first specified PRN medication; and 100 per cent, of the second PRN medication administration entries did not have corresponding follow-up notes regarding the effectiveness of the medications recorded on the eMAR. A review of the resident's electronic notes identified one entry related to the effectiveness of the second identified PRN medication administered in an identified month.

During an interview with RPN #110, they stated that resident #008 had identified PRN medications ordered for pain and that staff were supposed to document the effectiveness of PRN medications administered.

During an interview with RN #123, they acknowledged multiple missing entries related to the effectiveness of the identified PRN medications administered to resident #008 in the identified months. The stated that staff were required to document the effectiveness of each prn analgesic administered.

During an interview with the RAI Coordinator, they acknowledged that the PRN History report for resident #008, for a specific time period, did not contain documentation of the effectiveness of the identified PRN medications administered; the report for an identified month did not contain documentation of the effectiveness of the first identified PRN medication administered and contained one documented effectiveness entry for the second PRN medication administration which identified the resident slept well; the report for an identified month only had one entry documenting the effectiveness of the first PRN medication administered and did not contain documentation of the effectiveness of the second PRN medication that had been administered. The RAI Coordinator acknowledged that the MED e-care report they had generated identified resident #008 had an identified number of entries

where the follow-up effectiveness of prn medications administered, including analgesic medications, since the resident's admission, were not documented in the eMAR follow-up notes. The RAI Coordinator also acknowledged that the MED e-care report they had generated for the entire home for all current residents identified there were 4951 entries (on 496 pages) where the follow-up notes to the effectiveness of administered prn medications, including pain medications, were undocumented on the eMAR notes as required.

During an interview with the Best Practice RN, they acknowledged that there were multiple missing entries in the identified months, on the effectiveness of resident #008's PRN analgesic medications. The Nurse stated that staff were required to document the effectiveness of the prn analgesic medications administered.

During an interview with the Administrator, they reviewed the PRN History and Follow-Up List reports and progress notes for resident #008. They acknowledged multiple missing documentation each month for the administered PRN medications, and identified some months had zero or one follow-up effectiveness documented but should have had multiple entries. The Administrator stated staff were required to document the effectiveness of PRN analgesic medication. [s. 134. (a)] (625)

2. The most recent MDS assessment identified Resident #013 as having the prevalence of an identified level of pain.

The licensee policy, "Pain Management Toolkit - May 2016", indicated that the registered staff were to, "Document[s] the effectiveness of the interventions in the eMar with written follow up in the eNotes".

A review of the analgesia orders in MED e-care for resident #013, identified an identified scheduled medication and an identified prn medication.

During an interview with RPN #140, they reported to Inspector #196 that a prn dose of an identified medication had been administered. They further reported that there was no record of the effectiveness documented.

During an interview with RPN #126, they reported to the Inspector that registered staff would record the effectiveness of a prn medication in the eMar and the program would prompt the registered staff to enter the effectiveness, approximately one hour after administration.

During an interview with the Inspector, the RAI Coordinator, reviewed the eMar and confirmed that the reason for the prn medication administration on a specific shift on an identified date, for resident #013, was not identified, nor was the effectiveness documented or assessed. They further reported that it was a requirement for the registered staff to record this information.

During an interview with the DOC, they confirmed to the Inspector that registered staff were to document the effectiveness of prn analgesia in the eMar and this was in the policy and staff were to follow the medication policies. [s. 134. (a)]

The decision to issue a Compliance Order (CO) was based on the severity of this issue which was determined to be a level two, as there was minimal harm and potential for actual harm. The scope of the issue was a level three, as it was determined to be widespread. The home had a level two compliance history, as they had one or more unrelated areas of non-compliance in the past 36 months. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 22, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 59. Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,

(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and

(b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.

Order / Ordre :

The licensee must be compliant with s.59. (b) of O. Reg. 79/10.
Specifically, the licensee must:

a) Ensure that the Occupational Therapist (OT) assesses and responds to all referrals for Occupational Therapy services.

b) Review all pending OT referrals for residents, and ensure these residents are assessed.

c) Develop and implement a plan to ensure OT referrals are completed in a timely manner for all residents, for which referrals are received.

d)Maintain a record of the actions taken to address the above items.

Grounds / Motifs :

1. The licensee failed to ensure that therapy services for residents of the home were arranged or provided under section 9 of the Act that included, (b) occupational therapy and speech-language therapy.

A written complaint was submitted to the Director regarding resident #017's wound care treatment, weight loss and health decline since admission to the home on an identified date.

Refer to WN #2, finding #6 for further details.

The health care records for resident #107 were reviewed. The Physician's Orders written by MD #128 on an identified date, indicated that a specific intervention was to be put in place with OT consultation, and on another identified date indicated for an OT to assess for another intervention, and both orders indicated a referral was sent. The progress notes did not indicate that an OT consultation had occurred as a result of either referral.

During an interview with OT #141, they reported that they had received referrals to see resident #017 on identified dates, via email. The OT provided copies of the email referrals, and both indicated the referrals were upon the physician's request. The OT further reported that they only had three hours per week in the home and needed to prioritize the referrals and sometimes did not get to see everyone. The OT further reported that the resident was not assessed in relation to these referrals and no action was taken as a result of these referrals.

During an interview with the Administrator, they reported they would expect that the referrals to the OT would have been completed or some sort of communication from the OT that they had not assessed the resident. [s. 59. (b)]

The decision to issue a Compliance Order (CO) was based on, the severity of this issue which was determined to be a level two, as there was minimal harm and potential for actual harm. The scope of the issue was a level two, as the number of incomplete Occupational Therapy Assessments was a pattern. The home had a level two compliance history, as they had one or more unrelated areas of non-compliance in the past 36 months. (196)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 22, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee must be in compliance with s. 48. (1) (2) of O. Reg. 79/10. Specifically the licensee must:

a) Conduct an audit of all of the residents in the home requiring weekly identified assessments by registered nursing staff.

b) Complete a weekly wound assessment of the residents' areas of altered skin integrity, if required.

c) Establish an auditing routine to ensure that weekly identified assessments are being completed, as required.

d) Ensure the "Support Surface Selection Tool - RC-23-01-01-A4" is utilized, if required.

e) Ensure that an identified risk assessment is completed, at minimum, quarterly, if required.

f) Ensure that when a resident is assessed as being at a high risk for areas of altered skin integrity, their plan of care is updated, to include changes implemented to mitigate the risks of impaired skin integrity.

g) Maintain records of the actions taken with respect to the above items.

Grounds / Motifs :

1. The licensee has failed to ensure that the skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was implemented in the home.

a) A written complaint was submitted to the Director regarding resident #017's wound care treatment, weight loss and health decline since admission to the home on an identified date.

Refer to WN #2, finding #6 for further details.

The health care records for resident #017 were reviewed. An identified risk assessment that was completed at the time of admission, indicated the resident was

to be at a low risk of areas of altered skin integrity with an identified numerical score. The identified risk assessment completed on a specified date, indicated the resident had an identified higher numerical score, which identified a high risk of areas of altered skin integrity. The RAI MDS from identified dates, under an identified section, did not identify the use of a pressure relieving device for a chair or for a bed. The Physician's Orders did not include an order for a therapeutic surface on the bed. The care plan from admission through to date of transfer on an identified date, did not identify the use of a therapeutic surface in bed.

Together with Inspector #196, the Best Practice RN, reviewed the licensee's policies within the skin and wound program. The RN confirmed that with the high identified risk score documented on a specified date, and moderate assistance with bed mobility, the "Support Surface Selection Tool - RC-23-01-01-A4 - February 2017", identified that an air bed would have been the recommended support surface for resident #017.

During a further interview with the Best Practice RN, they reported that a nurse's recommendation, an MD order, or OT referral, could initiate the use of an air mattress or therapeutic surface for a resident's bed. They added that the use of a therapeutic surface in bed should have been included in the resident's care plan if it was used as an intervention to maintain skin integrity. They confirmed, after a review of the health care records, that a therapeutic surface in bed was not utilized for resident #017.

b) The licensee's skin and wound program titled "Wound Care Management: Prevention of Skin Breakdown – February 2017 – RC-23-01-01", read, "Ensure that the PURS is completed during quarterly MDS RAI assessment, and more often as required, and that risk mitigation strategies and interventions are implemented to address areas of risk or actual skin impairment".

The health care records for resident #017 were reviewed. The PURS was done after admission on an identified date, and scored an identified numerical score. There was no record that a PURS was conducted in an identified month. A subsequent PURS was conducted on an identified date, and the resident had higher identified numerical score. The care plan that was effective on an identified date, through until the identification of an area of altered skin integrity on an identified date , was unchanged.

During an interview with the Best Practice RN, they reported that the identified date PURS indicated a low risk for areas of altered skin integrity, confirmed the required quarterly PURS was not done in an identified month, and that the PURS on an identified date, had indicated a high risk for pressure ulcers. They further added, after a review of the care plan, that there had not been any changes implemented to have mitigated the risks of impaired skin integrity as indicated in the PURS assessment on an identified date. They further acknowledged that resident #017, developed an area of altered skin integrity, as identified in an identified assessment completed on an identified date; there were no changes to the plan of care as per the skin and wound care policy; and the resident had gone from a low risk to a high risk for areas of altered skin integrity. [s. 48. (1) 2.]

The decision to issue a Compliance Order (CO) was based on the severity of this issue which was determined to be a level three, as there was actual harm. The scope of the issue was a level three, as it was determined to be widespread. The outcome of this judgement was a Compliance Order (CO) as the home had a level two compliance history, as they had one or more unrelated areas of non-compliance in the past 36 months. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 22, 2019(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 19. (1) of the LTCHA. Specifically, the licensee must:

a) Ensure all residents, are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

b) Review the home's zero tolerance of abuse and neglect policies and identify how the home's staff failed to comply with the policies.

c) Educate all nursing and personal support services staff in their roles relating to the identified programs, specifically but not limited to, the administration and documentation of identified interventions.

d) Educate all nursing and personal support services staff in their roles relating to interdisciplinary team collaboration, specifically but not limited to, the home's policy, entitled, "Interdisciplinary Wound Care Team Roles-RC-23 -01-01-A1."

e) Maintain documentation of the education provided to all staff, the dates of the education, the content of the education, and the name of the person responsible for providing the education.

f)) Maintain records of the actions taken with respect to the above.

Grounds / Motifs :

1. The licensee failed to ensure residents were not neglected by the licensee or staff.

Ontario Regulation 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A written complaint was submitted to the Director regarding resident #017's wound care treatment, weight loss and health decline since admission to the home on December 29, 2017.

During an interview with complainant #200 and Inspector #196, they alleged neglect towards resident #017. They reported that they had been told of an area of altered skin integrity at a specified time; they had not seen the area of altered skin integrity themselves, until such time as the resident had been transferred to another healthcare facility in a specified month of an identified year. They indicated they were shocked that the resident had declined like this, had developed a area of altered skin integrity, and that an identified change had occurred.

The licensee failed to provide the resident with the treatment, care, services or assistance required for health, safety or well-being, which included inaction or a pattern of inaction that jeopardized the health, safety or well-being of the resident as follows:

a) With respect to Ontario. Reg. 79/10, s. 59. b), the licensee was required to ensure that therapy services for residents of the home were arranged or provided under section 9 of the Act that included occupational therapy.

The Physician's Orders written by MD #128 on an identified date, indicated for a specific intervention to be put in place by the OT, and on another identified date, indicated that the OT was to assess for another specified intervention, and both orders indicated a referral was sent. The progress notes did not indicate that a OT consultation had occurred as a result of either referral.

During an interview with OT #141,they reported that they had received referrals to see resident #017 on identified dates, via email. The OT provided copies of the email

referrals, and both indicated the referrals were upon the physician's request. The OT further reported that they only had three hours per week in the home and needed to prioritize the referrals and sometimes didn't get to see every one. The OT further reported that the resident was not assessed in relation to these referrals and no action was taken as a result of these referrals.

Refer to WN #6, finding #1 for further details.

b) With respect to the Long-Term Care Homes Act (LTCHA), 2007, s. 6. (9) 1, the licensee was required to ensure that the provision of the care set out in the plan of care following was documented.

On October 2, 2018, RD #108 conducted a nutritional assessment on resident #017, based upon a referral by the DOC regarding an intervention.

The health care records for resident #017 were reviewed. The RD orders on an identified date indicated for an intervention to be initiated at specified times. The progress notes written by the RD on this same date identified to initiate the intervention to provide additional calories and protein to resident #017 to support healing of areas of altered skin integrity and weight maintenance. The eMAR identified that the ordered intervention was initiated at a specified time on an identified date. The dietary flow sheets for an identified month indicated the provision of the intervention in specified amounts, on identified dates at specific times.

During an interview with the Best Practice RN, they reported to the Inspector that a new direction had been implemented on an identified date, that changed the process for staff to follow with regard to identified interventions. Specifically, the RPNs were no longer to provide or sign for the administration of identified interventions, as this was now a PSW task.

Together with the Inspector, the Best Practice RN reviewed the dietary flow sheet for the time period after an identified date, and confirmed the identified intervention was not recorded as provided at every specified time to resident #017 as had been ordered.

Refer to WN #2, finding #13 for further details.

c) With respect to Ontario. Reg. 79/10, s. 68. (2) (c), the licensee was required to ensure that the organized program of nutrition care and hydration included the implementation of interventions to mitigate and manage those risks.

The licensee failed to ensure that the nutrition care and hydration programs included, (c) the implementation of interventions to mitigate and manage those risks.

i)On an identified dates, RD #108 conducted a specific assessment on resident #017, based upon a referral by the DOC regarding identified interventions.

The health care records for resident #017 were reviewed. The RD orders on an identified date, indicated for an intervention to be discontinued. Initiate an identified intervention. The progress notes written by the RD on this same date identified that the staff on the floor were unable to notify writer if resident receives the intervention, and to initiate an intervention to provide additional calories and protein to promote healing of areas of altered skin integrity and for weight maintenance. The eMAR identified that the intervention was initiated at a specified time on an identified date.

During an interview with the Best Practice RN, they reported to the Inspector that registered staff had not processed the RD order for an identified intervention on a specified date, one week after the order was originally written.

During an interview with the DOC, they confirmed upon review of the Physician Orders that the second check of the orders was not done by the registered staff for the identified intervention and it was not started until one week after it had been ordered.

Refer to WN #14, finding #1 b), for further details.

ii)On an identified date, the RD #108 conducted an identified assessment on resident #017, as they had developed an identified area of altered skin integrity on an area of their body.

The health care records for resident #017 were reviewed. The Physician's Orders, indicated for an intervention to be added and that the POA was in agreement, additional protein requirements to support healing of areas of altered skin integrity. The care plan in effect at the time of the order included, the addition of the ordered

intervention. The eMAR did not include this RD order. The dietary records for identified months, did not include the provision of the identified intervention.

The progress notes written by the RD on an identified date, indicated that the staff on the floor were unable to notify writer if resident receives the intervention as ordered.

During an interview with the DOC, they confirmed upon review of the Physician Orders that the second check of the orders was not done by the registered staff for the identified intervention.

During an interview with RN #123, they reported that if a physician ordered treatment or a RD ordered an intervention, it was to be carried out as ordered.

During an interview with the Best Practice RN, they confirmed to the Inspector that there was no record that identified intervention had been provided at specific times since it had been ordered on an identified date. They further reported that the RD order had only one initial of a registered staff that had processed the order; should have had two checks by registered staff; and the order had never been put into the eMAR.

During an interview with the Administrator, they were informed that there was no record of the identified intervention having been provided to resident #017 as indicated in the RD orders written on an identified date. They further reported they would have expected that it would have been provided as ordered.

Refer to WN #14, finding #1 a), for further details.

d) With respect to the Long-Term Care Homes Act (LTCHA), 2007, s. 6. (4). (a), the licensee was required to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

i) The licensee policy titled, "Interdisciplinary Wound Care Team Roles - February 2017 - RC-23-01-01-A1" indicated that the nurse "Informs Wound Care Lead, Physician/NP of any new and/or worsening skin breakdown and as needed" and "Monitors all wounds with every dressing change".

The Physician's Orders from MD #128 identified that resident #017's area of altered skin integrity had not been assessed or observed after an identified date, through to a later identified date, as during those MD visits the resident was up. The Physician's Orders from an identified date indicated that if there were concerns about resident #017's areas of altered skin integrity then staff were to email a photo to the MD's email address, as provided, and on another identified date the same orders for concerns on another identified area of altered skin integrity.

The identified assessment tool, initiated on an identified date, indicated the area of altered skin integrity's measurements and characteristic, which according to the legend indicated a characteristic of the area. Documented identified assessments and dressing treatments on specified date, identified a specific rating, which indicated an identified characteristic. On an identified date, the area of altered skin integrity was identified as specified numerical score which indicated an identified characteristic. On identified dates, the base of the area of altered skin integrity was identified as a specified numerical score, which indicated a more severe characteristic.

The measurements as documented on the identified assessment, from a specified date range, were a specific measurement, with depth recorded between a specific measurement. There were no measurements completed on identified dates.

On an identified date, the physician's notes as recorded on the Physician Orders sheet, indicated the area of altered skin integrity was at least a certain measurement having a specific characteristic.

During an interview with the Best Practice RN, the progress notes were reviewed with the Inspector. There was no record of any emails with pictures sent to the MD, despite the area of altered skin integrity having been assessed as having progressed from a specific characteristic to another characteristic.

During an interview, the DOC, they reported to the Inspector, that as indicated in the identified assessment tool, the area of altered skin integrity progressed from a specific characteristic to another characteristic, which indicated a worsening and the physician should have been notified.

Refer to WN #2, finding #6 a), for further details.

ii) Inspector #196 reviewed the "Pain Management Toolkit" May 2016, as provided as the licensee's pain management program. The toolkit included the following: Interprofessional Team Monitoring, Registered Nursing Staff: "Ongoing assessment is done in collaboration with resident/family/SDM and other team members: when a resident exhibits a change in health status or pain is not relieved by initial interventions…for example PSW reports resident's experience of pain…" and "indicates that pain is present through family/staff/volunteer observation".

The "Pain Management Protocol (PSW)" indicated that the PSW staff were to document on flow sheet and in Med e-care…"PSW Reports to the RPN or RN". The "Pain Management Protocol (RN/RPN)" indicated upon "Direct report of resident in pain" then "RPN/RN completes pain assessment and documents".

The health care records for resident #017 were reviewed specific to pain. The care plan in effect, in an identified month indicated an area of pain, with a specific focus and expected outcome that the resident would be comfortable at all times, as well as an intervention to observe for signs of pain and report to Registered Staff when the resident was experiencing pain. The eMAR indicated the resident was started on an identified medication, on a specified date, and also had a PRN medication dose. The PRN administration history identified that a dose of the identified medication was last given on a specified date, for an unknown reason. No further PRN analgesia was documented as provided after this date through to another identified date. The progress notes were reviewed for an identified time period , and there was no indication recorded of resident pain.

During an interview, PSW #129 reported to Inspector #196 that they recalled having provided care to resident #017. In regard to discomfort, PSW #129 stated that this resident would respond in a specific way when they were repositioned in bed and they were in pain sometimes when turned in bed. PSW #129 was identified as #3 staff on the POC records for an identified month, and reported that if pain was observed during care then they would check pain for that resident on that shift in POC.

During interviews with PSW #129 and PSW #114, they demonstrated to the Inspector, the POC charting for pain experienced by a resident. There was an area to

check off titled, "complained or shows evidence of pain"; an area to record either verbal or observed complaints of pain and had check marks to indicate these complaints; and check mark area which read, "any pain symptoms should be reported to registered staff and documented". Both PSWs #129 and #114 reported that they would mark this off every shift, if a resident had pain, pain daily, and if the resident had reported either verbally or was observed to have pain and if reported to the nurse.

During an interview with the Best Practice RN, they reviewed resident #017's Flow Sheets from an identified month, in POC. The Flow Sheets from a specified date range, indicated that resident #017 was documented as having indicated pain symptoms less than daily on a specific number of shifts; physical signs of pain observed on a specific number of shifts; verbal complaints of pain on a specific number of shifts; and it was also documented on a specific number of shifts that any pain symptoms should be reported to registered staff and documented.

The Best Practice RN confirmed to the Inspector, that the most recent quarterly pain assessment was done on an identified date, which indicated a specified level of pain; the specific source, and identified tissues. The Best Practice RN further reported, there were no additional pain assessments completed after this date.

During an interview with the DOC, when questioned where the PSWs would record resident "pain symptoms", they reported it would be on the POC flow sheets. They further reported that there would be documentation in the eNotes and pain assessments that would reflect the communication of resident pain by the PSWs to the registered staff. The DOC reported to the Inspector, that they would expect some record of the communication of pain to the registered staff with regard to the POC documentation of pain from an identified date range, for resident #017. The DOC then confirmed the PSW documentation of observed resident pain in an identified month, had increased since the last pain assessment completed on an identified date, as this pain assessment noted the resident was comfortable with the current pain control.

Refer to WN #2, finding #6 b), for further details.

e) With respect to the Long-Term Care Homes Act (LTCHA), 2007, s. 6. (7), the

licensee was required to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

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.

The licensee's skin and wound program titled "Wound Care Management – February 2017 – RC-23-01-02", read, "Document all skin breakdown in the interdisciplinary progress notes (or wound progress note) and in surveillance tools".

The health care records for resident #017 were reviewed for information regarding the provision of care to an area of altered skin integrity. The care plan included the intervention of an identified treatment for the area of altered skin integrity. The Physician's Orders, from an identified date, indicated specific treatments for the area of altered skin integrity. The identified assessment tool for the specified month, did not have documentation of the ordered treatment or completed assessments on identified dates.

During an interview with the Best Practice RN, they reported to the Inspector that the registered staff were to fill out the identified assessment tool every time the treatment was completed. They further reported this tool also served as the weekly wound assessment.

During an interview with the DOC, they confirmed to the Inspector, upon review of the identified assessment tool, that the physician ordered treatments were not documented as completed on identified dates. They further reported if the treatment was "not charted, it was not done".

Refer to WN #2, finding #12 for further details.

f) With respect to Ontario. Reg. 79/10, s. 48. (1). 2, the licensee was required to ensure that the following interdisciplinary programs were developed and implemented in the home: 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.

The licensee has failed to ensure that the skin and wound care program to promote

skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was implemented in the home.

i)The licensee's skin and wound program titled "Wound Care Management: Prevention of Skin Breakdown – February 2017 – RC-23-01-01", read, "Ensure that the PURS is completed during quarterly MDS RAI assessment, and more often as required, and that risk mitigation strategies and interventions are implemented to address areas of risk or actual skin impairment".

The health care records for resident #017 were reviewed. The identified assessment was done after admission on an identified date, and scored a specified numerical score. There was no record that an identified assessment was conducted in a specified month. A subsequent identified assessment was conducted on an identified date, and the resident had a numerical score. The care plan that was effective on an identified date, through until the identification of an area of altered skin integrity, was unchanged.

During an interview with the Best Practice RN, they reported that the identified month identified assessment indicated a low risk for areas of altered skin integrity, confirmed the required quarterly identified assessment was not done in an identified month, and that the identified assessment completed on a specified date, had indicated a high risk for areas of altered skin integrity. They further added, after a review of the care plan, there had not been any changes implemented to have mitigated the risks of impaired skin integrity as indicated in the identified assessment on a specified date. They further acknowledged that resident #017, developed an area of altered skin integrity, as identified in an identified assessment tool dated a specified date; there were no changes to the plan of care as per the skin and wound care policy; and the resident had gone from a low risk to a high risk for areas of altered skin integrity.

Refer to WN #7, finding #4 b), for further details.

ii) The identified assessment completed at the time of admission, on an identified date, indicated the resident to be at a low risk of areas of altered skin integrity with a specified numerical score. The identified assessment completed on an identified date, indicated the resident had a higher numerical score, which identified a high risk

for areas of altered skin integrity. The RAI MDS dated a specified date, and on another specified date, under a specified section; did not identify the use of a pressure relieving device for a chair or for a bed. The Physician's Orders did not include an order for a therapeutic surface on the bed. The care plan from admission through to date of transfer, did not identify the use of a therapeutic surface in bed.

Together with Inspector #196, the Best Practice RN, reviewed the licensee's policies within the skin and wound program. The Best Practice RN confirmed that with the high risk identified assessment score on a specified date, and a specified level of assistance with bed mobility, the "Support Surface Selection Tool - RC-23-01-01-A4 - February 2017", identified that an air bed would have been the recommended support surface for resident #017.

During a further interview with the Best Practice RN, they reported that a nurse's recommendation, an MD order, or OT referral, could initiate the use of an air mattress or therapeutic surface for a resident's bed. They added that the use of a therapeutic surface in bed should have been included in the resident's care plan if it was used as an intervention to promote wound healing. They confirmed, after a review of the health care records, that a therapeutic surface in bed was not utilized for resident #017.

Refer to WN #7, finding #4 a), for further details.

In summary, resident #017 was not provided with the treatment, care, services, or assistance required for their health, safety or well-being, in areas related to the skin and wound care program. [s. 19. (1)]

The decision to issue a Compliance Order (CO) and Director Referral (DR) was based on the severity of this issue which- was determined to be a level three, as there was actual harm. The scope of the issue was a level three, as it was determined to be widespread. In addition, the home's compliance history identified an ongoing history of non-compliance specific to this area of the legislation. The home has a history of non-compliance in this area of the legislation as follows:
- a Compliance Order (CO) was issued from a Resident Quality Inspection (RQI) #2018_703625_000, on March 26, 2018; and
- a CO and Director Referral (DR) were issued from a RQI #2016_333577_0012, on October 24, 2016. (196)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Aug 22, 2019(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

The written request for review must be served personally, by registered mail, 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:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health 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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 10th day of July, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by RYAN GOODMURPHY (638) - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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