Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 1, 2021	2021_661683_0005	003945-21, 004315-21, 004695-21, 005067-21, 005420-21	Complaint

Licensee/Titulaire de permis

Blackadar Continuing Care Centre Inc.
101 Creighton Road Dundas ON L9H 3B7

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

Blackadar Continuing Care Centre
101 Creighton Road Dundas ON L9H 3B7

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

LISA BOS (683), EMMY HARTMANN (748)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 26, 29, 30, 31, April 1, 6, 7, 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22 and 26, 2021.

The following intakes were completed during this complaint inspection:
Log #003945-21 was related to skin and wound, safe and secure home, personal support services, medication administration, dining, trust accounts, infection prevention and control, reporting and complaints;
Log #004315-21 was related to skin and wound, the prevention of abuse and neglect, laundry services, personal support services and safe and secure home;
Log #004695-21 was related to nutrition and hydration, dining, personal support services, staffing, housekeeping and laundry services, admissions, the prevention of abuse and neglect, medication administration, infection prevention and control, safe and secure home;
Log #005067-21 was related to staffing; and
Log #05420-21 was related to skin and wound, infection prevention and control and staffing.

During the course of the inspection, the inspector(s) spoke with the Extendicare Regional Director, Extendicare Nursing Consultant (Acting Director of Care), Administrator, Resident Program Manager, Food and Environmental Services Manager, Consultant Pharmacist, maintenance staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

During the course of the inspection, the Inspector(s) toured the home, observed the provision of care, meal service, resident and staff interactions, infection prevention and control practices and reviewed clinical health records, relevant home policies and procedures, internal investigation notes, meeting minutes and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Admission and Discharge
Dining Observation
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Trust Accounts

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

- **14 WN(s)**
- **8 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, when they developed new skin impairments.

The home's policy indicated that there was a clinically appropriate assessment instrument to conduct skin assessments.

The Impaired Skin Integrity Assessment in Point Click Care (PCC) had areas for the type of skin impairment which included skin tears and redness; the measurements (length x width); the skin tear category; the description and characteristics of the impairment; signs and symptoms of pain or infection; improvement, deterioration, or healing of the wound; and referrals and notifications.

A Registered Practical Nurse (RPN) and Registered Nurses (RN) identified that the assessment of redness and skin tears was completed and documented within PCC.

A) A resident's progress notes indicated that an area of their body remained edematous and red.

The resident's Weekly Impaired Skin Integrity Assessments identified that there was no initial assessment completed for the redness when it was first identified.

B) A resident's progress notes indicated that their skin was warm to touch, edematous, shiny, red, inflamed, and that an infection was suspected. They also had an area of altered skin integrity that was cleansed and dressed, and the doctor was notified. The next day, the resident was started on a medication for the suspected infection. The Weekly Impaired Skin Integrity Assessments indicated that the redness was already identified five days prior to the above noted progress note, however, an initial assessment of the resident's area of altered skin integrity was not completed, and the resident's progress notes did not identify when the area healed or resolved.

A clinically appropriate tool that looked at a comprehensive assessment, including improvement and deterioration, was not completed on the areas of altered skin integrity for either resident when the impairments were first identified. As a result, a resident was at risk for not having the appropriate interventions implemented to address any change in the status of their skin impairment. Additionally, there was a risk that a resident would not receive the necessary interventions for their area of altered skin integrity, as the lack of the initial assessment resulted in no subsequent assessment of the area.

The Administrator acknowledged that wound care assessments were not completed for the residents when their skin impairments were first identified.

Sources: Resident progress notes and Weekly Impaired Skin Integrity Assessment; Skin and Wound Program: Wound Care Management policy; interviews with a RPN, RNs and the Administrator. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff.

A RN indicated that altered skin integrity was clinically indicated to be assessed on a weekly basis and the assessments were found in PCC.

A) A resident's written plan of care identified that they had an area of altered skin integrity and their Treatment Administration Record (TAR) identified that it was to be assessed weekly using the wound assessment in PCC.

The resident's wound care assessments identified that their area of altered skin integrity was not assessed on a weekly basis on six occasions over a period of approximately four months.

A RPN verified that the resident's area of altered skin integrity should have been assessed every week and acknowledged that was not completed.

B) A resident’s written plan of care identified that they had areas of altered skin integrity.

The resident’s wound care assessments indicated that after one of their areas of altered skin integrity was first identified, another assessment was not completed until 17 days later. Their wound care assessments also indicated that their other area of altered skin integrity had a gap of 21 days between assessments.

A RN acknowledged that the resident’s areas of altered skin integrity were to be assessed every week, but the assessments were not completed on a weekly basis.

C) A resident’s written plan of care identified that they had a recurrent infection related to an area of altered skin integrity.

A RN identified that the resident's area of altered skin integrity was to be monitored on a weekly basis.

A RPN and RN identified that the weekly skin assessments were documented in PCC.

The resident's Weekly Impaired Skin Integrity Assessments showed a gap of approximately five weeks between assessments where their area of altered skin integrity was not assessed.

The Administrator acknowledged the weekly assessments were not completed.

There was a risk that any change in the status of the three identified resident’s wounds, including any deterioration, would not be identified and interventions not implemented, as weekly assessments by registered staff were not completed.

Sources: Resident care plans, wound assessments in PCC; home's Wound Care

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

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 Medical Director.

Ontario Regulation 79/10 defines a medication incident as a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription, and includes,
(a) an act of omission or commission, whether or not it results in harm, injury or death to a resident, or
(b) a near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted.

The medical director was not notified of the following medication incidents that were discovered by a RN:
-A medication incident identified to be pharmacy-related whereby the wrong directions were placed on a resident's blister pack.
-A medication incident identified to be pharmacy-related whereby the nurse was unable to administer a medication as it was not available.

The Consultant Pharmacist confirmed that the medical director was to be notified of all medication incidents.

A RN verified that they did not notify the medical director for the two medication incidents they discovered.

Sources: The home's Medication Incident Reports for 2021, and Medication Incident and Reporting policy, last updated December 2019; interview with the Consultant Pharmacist and a RN. [s. 135. (1)]

2. The licensee has failed to ensure that all medication incidents were reviewed and analyzed, and that corrective actions were taken as necessary.

Four medication incidents were reported in 2021. Three were pharmacy-related pertaining to an error in dispensing, and labelling of medications, and one was nursing-related pertaining to an error in administration of a medication.

The nursing-related medication incident indicated that a previous dose of a medication

was reduced. It was identified that an extra tablet of the medication was given to the resident when a RN discovered that the discontinued blister pack contained the wrong count. The RN confirmed with the RPN who worked at the time of the incident, that an extra dose was given to the resident.

There was an investigation section on the medication incident report, which included a section to be filled out related to contributing factors, root cause of the incident, comments or corrective action to prevent recurrence, and date corrective actions were implemented; however, the investigation section was blank.

Two of the pharmacy-related medication incidents were related to delivery issues and availability of a medication which lead to a resident not receiving their medication as prescribed. The third pharmacy-related medication incident was pertaining to the wrong directions written by pharmacy on a resident's medication.

The acting Director of Care (DOC) identified that the review, analysis, and corrective actions were not completed for the nursing-related medication incident.

The Consultant Pharmacist identified medication incidents were submitted to the pharmacy via the Medication Incident Reporting System (MIRS) and that when it was reported, there was a nursing review portion completed by the home, and once this was completed, the pharmacy conducted their review including identifying and implementing corrective actions. They verified that the review, analysis, and implementation of corrective actions for the pharmacy-related medication incidents were not completed, as the home had not completed the nursing review portion.

There was a high risk of recurrence of medication incidents as the home did not review and analyze medication incidents that were reported, including identifying root causes and contributing factors to the incidents. Thus, the safety of residents was at high risk related to medication management.

Sources: The home's Medication Incident Reports for 2021; interview with the Consultant Pharmacist and Acting Director of Care. [s. 135. (2)]

3. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home to reduce and prevent medication incidents.

Four medication incidents were reported in 2021. Three were pharmacy-related pertaining to an error in dispensing, and labelling of medications, and one was nursing-related pertaining to an error in administration of a medication.

The nursing-related medication incident indicated that a previous dose of a medication was reduced. It was identified that an extra tablet of the medication was given to the resident when a RN discovered that the discontinued blister pack contained the wrong count. The RN confirmed with the RPN who worked at the time of the incident, that an extra dose was given to the resident.

Two of the pharmacy-related medication incidents were related to delivery issues and availability of a medication which lead to a resident not receiving their medication as prescribed. The third pharmacy-related medication incident was pertaining to the wrong directions written by pharmacy on a resident's medication.

The home's Medication Incident and Reporting policy stated to review all medication incidents, adverse drug events, and corrective action plans at the home's Medical/Professional Advisory Committee.

The Consultant Pharmacist identified that they had not participated in a quarterly review of all medication incidents that have occurred in the home, in order to reduce and prevent medication incidents.

The Administrator identified that a quarterly review of all medication incidents to reduce and prevent medication incidents, was not completed for 2020 including the first quarter of 2021.

There was a risk that necessary changes and improvements to prevent medication incidents would not be implemented, as a review of the medication incidents in the home, which included errors in dispensing, labelling, and administration of medications, were not being conducted quarterly. This posed a risk to the safety of residents related to medication management.

Sources: The home's Medication Incident Reports for 2021, and Medication Incident and Reporting policy; interview with the Consultant Pharmacist, and the Administrator. [s. 135. (3)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home was a safe and secure environment for its residents when active screening for COVID-19 was not occurring as per Directive #3.

As of April 24, 2020, Long-Term Care homes were required to immediately implement active screening of all staff, visitors and anyone else entering the home for COVID-19, with the exception of first responders. The active screening was required to include twice daily (at the beginning and end of the day or shift) symptom screening and temperature checks.

A complaint was received regarding the home not actively screening staff upon the start and end of their shifts.

RNs, a RPN and Personal Support Workers (PSW) indicated that when they finished their shifts, they screened themselves out by taking their own temperature and signing the appropriate form. A RN indicated that they did not receive any direction that they were responsible to screen staff out.

The home's Resident Program Manager indicated that the screener was present at the entrance of the home from 0500 to 1700 hours, and after that staff screened themselves in and out. The Extendicare Nursing Consultant, who was acting as the Director of Care (DOC), indicated that the home previously had a staff member present to screen staff until 2300 hours, but the home recently changed the hours of the shift without their knowledge. They acknowledged that when the screener was not present, active screening was not occurring.

By not actively screening staff at the beginning and end of the day or shift, it increased the chances of COVID-19 symptoms not being identified.

Sources: Directive #3, a complaint submitted to the Director; interviews with RNs, a RPN, PSWs, the Resident Program Manager and the Extendicare Nursing Consultant. [s. 5]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, that the plan was complied with.

In accordance with O. Reg. 79/10 s. 230 (1) and in reference to LTCHA s. 87 (1), the licensee is required to ensure that their emergency plans provide for dealing with the loss of one or more essential services.

Specifically, staff did not comply with the home's Loss of Essential Services policy which identified that in the event of a power failure:
a) The home must describe in the Emergency Response Plan the contingency plan for a generator or access to a generator that will be operational within three hours of a power outage.
b) The incident manager must assign a person to supervise all doors leading to the outside and stairwells until power is restored.

c) If call bells are not working, resident checks must be completed and documented every 15 minutes. Appendix 2 contains a 24-Hour Resident Check Log.

There was a power outage that affected the home for approximately 5.75 hours.

The home was unable to provide the Inspector a copy of their Emergency Response Plan, as required in their Loss of Essential Services policy. The Administrator acknowledged that they did not have a contingency plan in place for access to a generator that would be operational within three hours of a power outage that could maintain the required systems.

A RN confirmed they were working on the date of the power outage and although they assigned staff to monitor the stairwell doors, three residents were found in the stairwells. A PSW indicated that instead of a staff member monitoring the stairwells, chairs were placed in front of the stairwell doors when they needed to provide care to residents. At Blackadar Continuing Care Centre, residents reside on the second and third floors of the building, therefore by entering unattended stairwells, residents were at risk of falling down the stairs.

A RN acknowledged that the 24-hour Resident Check Log as referenced in the home's loss of Essential Services policy was not completed. They indicated that they completed their own checks, but there was no documentation available to confirm that 15-minute resident checks were completed, as per the home's policy. The maintenance staff member confirmed that the home's call bells did not work in a power outage.

Sources: Loss of Essential Services policy; interview with a RN, PSW, maintenance staff member and the Administrator. [s. 8. (1)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with Ontario Regulation 79/10, s. 48 (1) 2, the licensee was to ensure that 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, was developed and implemented in the home.

Specifically, staff did not comply with the licensee’s "Skin and Wound Program: Prevention of Skin Breakdown" which stated that a head to toe assessment was to be

completed on residents on admission and upon any return from hospital; and also;
a. Upon any return from an absence greater than 24 hours
b. Quarterly and;
c. As clinically indicated.

A) A resident’s written plan of care identified that they had areas of altered skin integrity.

A head to toe skin assessment was completed on the resident after a return from hospital, but no other assessments were completed, for a gap of nine months, or three assessments missed.

B) A resident’s written plan of care identified that they had areas of altered skin integrity.

The resident's head to toe assessments showed a gap of six months in between assessments, or one assessment missed.

C) A resident’s written plan of care identified that they had a recurrent infection related to an area of altered skin integrity.

The resident's last head to toe assessment was reviewed and there was a gap of nine months, or three assessments missed.

Two RNs verified that head to toe assessments were to be completed quarterly, but that the three residents identified above did not have quarterly assessments completed.

There was a risk that skin breakdown would not be identified on the residents, as their head to toe assessments were not completed quarterly, as per the home's policy.

Sources: Resident care plans and assessments; the home's Prevention of Skin Breakdown policy; interviews with RNs. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan or policy, the licensee is required to ensure that the plan or policy is complied with, to be implemented voluntarily.

WN #5: 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, a resident was assessed in accordance with prevailing practices to minimize risk to the resident.

A complaint was submitted to the Director regarding bed rail assessments not being completed by the home.

According to a prevailing practice titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and other Hazards," Health Canada recommends that patients be re-assessed for risk of entrapment whenever there is a change in the patient's medication or physical condition.

The home's bed rail safety policy directed nursing staff to complete an assessment in

collaboration with the interdisciplinary team and resident/substitute decision maker quarterly, at minimum, or more often as required based on changes to the resident's need for bed rails.

The home's bed entrapment testing policy identified that bed entrapment testing would be conducted annually for the seven zones of entrapment as outlined in the Health Canada Guidance Document identified above and the results were to be documented.

A) A resident was observed in bed with bedrails in place. A review of their clinical record identified that they recently had a significant change in condition and a new bed rail safety assessment was not completed. Their most recent bed entrapment testing was completed over three years ago.

A RN and RPN indicated that after the Quality Control RPN left their position at the home, the task of completing quarterly bed rail assessments was not assigned to other nursing staff. Registered staff reviewed the resident's clinical record and acknowledged that they had a significant change in status and that a bed rail assessment was not completed quarterly for the resident as per the home's policy.

A resident had a change in condition and they were not re-assessed for risk of entrapment as per prevailing practices and as per the home's policies, which meant that risk for bed rail related incidents may have gone unnoticed.

Sources: Health Canada Guidance Document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards"; Bed Rail Safety; Bed Entrapment Testing policy; interviews with RNs and a RPN.

B) The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A resident was observed in bed with bed rails in place.

The resident had a bed rail safety assessment completed which identified that they were at a high risk of bed entrapment. The home was unable to provide any documentation of bed entrapment testing being completed for their bed system. This was confirmed by the Administrator and the home's maintenance staff member, who was responsible for completing entrapment testing.

A resident was identified at a high risk of bed entrapment and entrapment testing was not completed on their bed system, which put them at risk for injury.

Sources: Bed Entrapment Testing policy; interviews with Administrator and maintenance staff. [s. 15. (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 where bed rails are used, the resident is assessed in accordance with prevailing practices, to minimize risk to the resident and steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 19. Generators

Specifically failed to comply with the following:

s. 19. (4) The licensee of a home to which subsection (2) or (3) applies shall ensure, not later than six months after the day this section comes into force, that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1) (a), (b) and (c). O. Reg. 79/10, s. 19 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that they had guaranteed access to a generator that would be operational within three hours of a power outage and that could maintain the heating system, emergency lighting and essential services.

Blackadar Continuing Care Centre is a three-story Long-Term Care Home with Class C beds within the meaning of subsection 187 (18) of the Act.

The home's Loss of Essential Services Policy indicated that "in the event the home does not have a generator on site, the home must describe in the Emergency Response Plan, where possible, the contingency plan for a generator or access to a generator that will be

operational within three hours of a power outage and can maintain, at a minimum: the telephone system, fire alarm system, resident-staff communication and response system, emergency lighting in the hallways and stairwells, safety and emergency equipment, life safety systems, heating systems, and other items ad required."

A complaint was received regarding a power outage at the home. The complainant indicated that the power was out for approximately 5.75 hours and there was no backup generator which affected resident care.

The Administrator acknowledged that the home had a power outage. They indicated that they had a small generator that only lasted a few hours and emergency lighting in the hallways was powered by batteries so only lasted a few hours. They acknowledged that it did not power the resident-staff communication and response system and elevators. Both the Administrator and maintenance staff member were unsure if the generator powered the heating system or any emergency plugs and they both acknowledged that there were no electrical plugs in the home in which they were aware of that were identifiable as emergency power.

The Administrator acknowledged that the home did not have any contracts or agreements for access to a generator that would be operational within three hours of a power outage because they were under the impression that they had until 2025 to have that in place. They confirmed that a generator was not brought in on the date of the power outage that lasted for approximately 5.75 hours.

Without access to a generator that would be operational within three hours of a power outage that could maintain the required systems, it put residents at risk of not receiving the care or services they required.

Sources: A complaint submitted to the Director; Loss of Essential Services policy; interview with the Administrator, maintenance staff member, and other staff. [s. 19. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain the heating system, emergency lighting in hallways, corridors, stairways and exits; and essential services, including the resident-staff communication and response system, elevators and life-support, safety and emergency equipment., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which included the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The Medication Management Binder identified a section titled "evaluation"; however, it did not contain any documentation of a quarterly evaluation of the home's medication management system.

The Consultant Pharmacist identified that they had not participated in a meeting which evaluated the effectiveness of the medication management system in the home.

The Administrator confirmed that the home did not complete a quarterly evaluation of their medication management system.

Sources: Medication Management Binder; interviews with the Consultant Pharmacist and Administrator. [s. 115. (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 an interdisciplinary team which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which included the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The Medication Management Binder identified a section titled "evaluation"; however, it did not contain any documentation of an annual evaluation of the home's medication management system.

The Consultant Pharmacist identified that they had not participated in a meeting which evaluated the effectiveness of the medication management system in the home.

The Administrator confirmed that the home did not complete an annual evaluation of their medication management system.

Sources: Medication Management Binder; interviews with the Consultant Pharmacist and Administrator. [s. 116. (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 an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(c) that the local medical officer of health is invited to the meetings; O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control interdisciplinary team met at least quarterly.

Review of the home's Infection Prevention and Control meeting minutes indicated that in 2020, three meetings were held. The home's Director of Care, Quality Care RPN, Food Services and Environmental Manager, Resident Program Manager and Administrator were in attendance. The Administrator indicated that there were no formal Infection Prevention and Control meetings so far in 2021, but acknowledged that they have had informal meetings regarding IPAC, specifically around their COVID-19 outbreaks. The Administrator was unable to provide any documentation of meetings since October 2020.

Sources: Infection Prevention and Control meeting minutes; interview with the Administrator. [s. 229. (2) (b)]

2. The licensee has failed to ensure that the local Medical Officer of Health was invited to the Infection Prevention and Control team meetings.

Review of the home's Infection Prevention and Control meeting minutes indicated that in 2020, three meetings were held. The home's Director of Care, Quality Care RPN, Food Services and Environmental Manager, Resident Program Manager and Administrator were in attendance. The Administrator acknowledged that the local Medical Officer of Health was not invited to attend the meetings in 2020. The Administrator indicated that there were no formal Infection Prevention and Control meetings so far in 2021, but acknowledged that they had informal meetings regarding IPAC, specifically around their COVID-19 outbreaks, and indicated that Public Health was involved in those discussions. The Administrator was unable to provide any documentation of meetings held in 2021.

Sources: Infection Prevention and Control meeting minutes; interview with the Administrator. [s. 229. (2) (c)]

3. The licensee has failed to ensure that the Infection Prevention and Control program was evaluated at least annually.

The Administrator indicated that there were changes made to the home's IPAC program in 2020 as a result of the COVID-19 pandemic but acknowledged that the IPAC program was not evaluated in 2020 and was unable to provide any documentation to support any changes made to the program and the dates the changes were implemented.

Sources: Interview with the Administrator [s. 229. (2) (d)]

4. The licensee has failed to ensure that all staff participated in the implementation of the

infection prevention and control program.

The Long-Term Care home was in a COVID-19 outbreak and all residents on the third floor of the home were placed on contact and droplet precautions, as confirmed by a RN and the Resident Program Manager.

Upon tour of the home, the Inspector did not observe signage posted at the stairway entrances of the third floor indicating that the home area was in outbreak, as confirmed by a RPN.

Sources: Observations of the third floor of the home; interview with a RN, RPN and the Resident Program Manager. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Infection Prevention and Control (IPAC) interdisciplinary team meets at least quarterly, that the local Medical Officer of Health is invited to the IPAC team meetings, that the IPAC program is evaluated at least annually and that all staff participate in the implementation of the IPAC program, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (7) The licensee shall,
(a) test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(b) test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(c) conduct a planned evacuation at least once every three years; and O. Reg. 79/10, s. 230 (7).
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans. O. Reg. 79/10, s. 230 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the emergency plans related to the loss of essential services were tested on an annual basis.

A complaint was received regarding a power outage of approximately 5.75 hours at the home which affected resident care.

The home did not have guaranteed access to a generator that could power essential services. The Administrator and maintenance staff member indicated that they were unsure exactly what the home's small backup generator powered. There was no documentation that the emergency plans related to the loss of essential services were tested within the past year and the Administrator acknowledged it was not done.

By not testing the emergency plans related to the loss of essential services annually, the home was unaware of what services were available in the event of a power outage, which affected the quality of care delivered to the residents.

Sources: A complaint submitted to the Director; Interview with the Administrator, maintenance staff member, and other staff. [s. 230. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that they test the emergency plans related to the loss of essential services on an annual basis, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (6) The licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m. O. Reg. 79/10, s. 71 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that the evening meal was not served before 5:00 pm.

A complaint was received regarding meal service.

Dinner service was observed on the first, second and third floors of the home. Signage outside the dining room on the first floor indicated that meal service was to begin at 5:00 pm. At 4:50 pm, meal service on one of the floors had already been completed.

At 5:06 pm, staff were finished serving the meals on one of the floors and leftover food was being removed from the home area.

The Food Service Manager indicated that when the home was in a COVID-19 outbreak, they directed staff to start meal service at 4:45 pm on all floors, but acknowledged that the home was no longer in a COVID-19 outbreak and that they did not change the meal time back to 5:00 pm.

Sources: Complaint submitted to the Director; dining observations, interview with the Food Service Manager [s. 71. (6)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included course by course meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

A complaint was received regarding meal service.

Dinner service was observed in the home. One one home area, some residents were seated at tables in the hallway and other residents were seated in the dining room. Upon observation, the majority of the residents in the hallway were served their main course and had their dessert served to them at the same time, and some residents were served their dessert, and had not been served their main course yet. The written plan of care was reviewed for two of the residents who were served their dessert before their main course, and their care plans did not specify that course by course meal service was not required.

The PSW who served the desserts indicated that they gave the desserts out prior to the main course or when residents were still eating their main course because they were short one PSW that shift. They indicated that there were three PSWs working on the home area at the time.

The Administrator and the Food Service Manager acknowledged that the residents should have been served course by course.

Sources: A complaint submitted to the Director; dining observations; interviews with a PSW, the Administrator and Food Service Manager [s. 73. (1) 8.]

2. The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

A complaint was received regarding meal service.

i) Dinner service was observed in the home. Two resident's written plans of care indicated that they required total assistance with eating. They were observed with a plate of food in front of them on the table and a staff member was not available to provide the assistance they required.

ii) Inspector #683 observed an uncovered plate of food sitting at an unattended table. A PSW indicated that it was for a resident, who had not been brought into the dining room for meal service yet. The resident's written plan of care indicated that they required total assistance with eating. Their food was placed at their table when they were not in the dining room and when there was not a staff member available to provide the assistance they required.

The Administrator and Food Service Manager acknowledged that residents should not be served a meal until someone was available to provide assistance to them.

Sources: Complaint submitted to the Director; dining observations, interview with a PSW, the Administrator and the Food Service Manager [s. 73. (2) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Findings/Faits saillants :

1.The licensee has failed to ensure that the Director was immediately informed of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

As per the Critical Incident (CI) report, the home went into a COVID-19 outbreak. The CI report was not submitted to the Director until two days after the outbreak was declared.

In an interview with the Administrator, they acknowledged that the report was made to the Director two days after the outbreak was declared.

Sources: CI report; interview with the Administrator. [s. 107. (1) 5.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The has licensee failed to ensure that all areas where drugs were stored were kept locked at all times when not in use.

A door by the nursing station which had a sign stating "door must be locked at all times" was closed but unlocked. The area was not being used at the time, and the contents behind the door contained resident charts and drugs.

A RN confirmed that this area by the nursing station contained drugs and that it was supposed to be kept locked when it was not in use.

There was a risk to the security of drugs in the home as a door containing drugs was left unlocked when it was not in use.

Sources: Observation; interview with a RN. [s. 130. 1.]

Issued on this 4th day of June, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	LISA BOS (683), EMMY HARTMANN (748)
Inspection No. / No de l’inspection :	2021_661683_0005
Log No. / No de registre :	003945-21, 004315-21, 004695-21, 005067-21, 005420-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 1, 2021
Licensee / Titulaire de permis :	Blackadar Continuing Care Centre Inc. 101 Creighton Road, Dundas, ON, L9H-3B7
LTC Home / Foyer de SLD :	Blackadar Continuing Care Centre 101 Creighton Road, Dundas, ON, L9H-3B7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Shelly Desgagne

To Blackadar Continuing Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must comply with section 50 (2) of Ontario Regulation 79/10.

Specifically, the licensee shall ensure that:
1. Residents receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate instrument that is specifically designed for skin and wound assessments when they develop new skin impairments.
2. Residents skin impairments are re-assessed weekly by a member of the registered nursing staff.
3. A weekly audit is completed to ensure that new skin impairments are assessed using a clinically appropriate tool; and that residents with altered skin integrity are reassessed weekly, if clinically indicated. The audits are to be completed for a minimum of one month, or until all staff are compliant with the process.
4. Documentation of the audit is kept, including when the audit was completed, what the findings were, the corrective actions taken, and who completed the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that residents received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, when they developed new skin impairments.

The home's policy indicated that there was a clinically appropriate assessment instrument to conduct skin assessments.

The Impaired Skin Integrity Assessment in Point Click Care (PCC) had areas for the type of skin impairment which included skin tears and redness; the measurements (length x width); the skin tear category; the description and characteristics of the impairment; signs and symptoms of pain or infection; improvement, deterioration, or healing of the wound; and referrals and notifications.

A Registered Practical Nurse (RPN) and Registered Nurses (RN) identified that the assessment of redness and skin tears was completed and documented within PCC.

A) A resident's progress notes indicated that an area of their body remained edematous and red.

The resident's Weekly Impaired Skin Integrity Assessments identified that there was no initial assessment completed for the redness when it was first identified.

B) A resident's progress notes indicated that their skin was warm to touch, edematous, shiny, red, inflamed, and that an infection was suspected. They also had an area of altered skin integrity that was cleansed and dressed, and the doctor was notified. The next day, the resident was started on a medication for the suspected infection. The Weekly Impaired Skin Integrity Assessments indicated that the redness was already identified five days prior to the above noted progress note, however, an initial assessment of the resident's area of altered skin integrity was not completed, and the resident's progress notes did not identify when the area healed or resolved.

A clinically appropriate tool that looked at a comprehensive assessment, including improvement and deterioration, was not completed on the areas of altered skin integrity for either resident when the impairments were first identified. As a result, a resident was at risk for not having the appropriate interventions implemented to address any change in the status of their skin impairment. Additionally, there was a risk that a resident would not receive the necessary interventions for their area of altered skin integrity, as the lack of the initial assessment resulted in no subsequent assessment of the area.

The Administrator acknowledged that wound care assessments were not completed for the residents when their skin impairments were first identified.

Sources: Resident progress notes and Weekly Impaired Skin Integrity Assessment; Skin and Wound Program: Wound Care Management policy; interviews with a RPN, RNs and the Administrator. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff.

A RN indicated that altered skin integrity was clinically indicated to be assessed

on a weekly basis and the assessments were found in PCC.

A) A resident's written plan of care identified that they had an area of altered skin integrity and their Treatment Administration Record (TAR) identified that it was to be assessed weekly using the wound assessment in PCC.

The resident's wound care assessments identified that their area of altered skin integrity was not assessed on a weekly basis on six occasions over a period of approximately four months.

A RPN verified that the resident's area of altered skin integrity should have been assessed every week and acknowledged that was not completed.

B) A resident's written plan of care identified that they had areas of altered skin integrity.

The resident's wound care assessments indicated that after one of their areas of altered skin integrity was first identified, another assessment was not completed until 17 days later. Their wound care assessments also indicated that their other area of altered skin integrity had a gap of 21 days between assessments.

A RN acknowledged that the resident's areas of altered skin integrity were to be assessed every week, but the assessments were not completed on a weekly basis.

C) A resident's written plan of care identified that they had a recurrent infection related to an area of altered skin integrity.

A RN identified that the resident's area of altered skin integrity was to be monitored on a weekly basis.

A RPN and RN identified that the weekly skin assessments were documented in PCC.

The resident's Weekly Impaired Skin Integrity Assessments showed a gap of approximately five weeks between assessments where their area of altered skin integrity was not assessed.

The Administrator acknowledged the weekly assessments were not completed.

There was a risk that any change in the status of the three identified resident's wounds, including any deterioration, would not be identified and interventions not implemented, as weekly assessments by registered staff were not completed.

Sources: Resident care plans, wound assessments in PCC; home's Wound Care Management policy; interviews with RPNs, RNs and the Administrator.

An order was made by taking the following factors into account:

Severity: Due to the lack of assessments, residents with new and ongoing skin impairments were at minimal risk for not having timely and appropriate interventions to manage their skin impairments.

Scope: This was a widespread issue as two of three residents did not have a skin assessment using a clinically appropriate instrument designed for skin and wound assessments, when they developed new skin impairments. Three of three residents, that had skin impairments that were clinically indicated to be assessed, did not have weekly assessments completed.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with Ontario Regulation 79/10 s. 50 (2) b, and a compliance order was issued in May 2019. (748)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 02, 2021

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Order / Ordre :

The licensee must comply with section 135 (2) of Ontario Regulation 79/10.

Specifically, the licensee shall ensure that:
1. All medication incidents are reviewed, and analyzed.
2. The review includes an identification of root causes, and contributing factors to the medication incidents.
3. Corrective actions are implemented to prevent recurrence of a medication incident, including re-education, and re-training of staff, as needed.
4. The home collaborates with their pharmacy provider in the review, analysis, and implementation of corrective actions.
5. An audit is completed to ensure that medication incidents are reviewed, analyzed, and corrective actions implemented.
6. Documentation of the review, analysis, and implementation of corrective actions; and audits, are kept, including the date of completion, and the participants involved.

Grounds / Motifs :

1. The licensee has failed to ensure that all medication incidents were reviewed and analyzed, and that corrective actions were taken as necessary.

Ontario Regulation 79/10 defines a medication incident as a preventable event associated with the prescribing, ordering, dispensing, storing, labelling,

administering or distributing of a drug, or the transcribing of a prescription, and includes,
(a) an act of omission or commission, whether or not it results in harm, injury or death to a resident, or
(b) a near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted.

Four medication incidents were reported in 2021. Three were pharmacy-related pertaining to an error in dispensing, and labelling of medications, and one was nursing-related pertaining to an error in administration of a medication.

The nursing-related medication incident identified that a previous dose of a medication was reduced. It was identified that an extra tablet of the medication was given to the resident when a RN discovered that the discontinued blister pack contained the wrong count. The RN confirmed with the RPN who worked at the time of the incident, that an extra dose was given to the resident.

There was an investigation section on the medication incident report, which included a section to be filled out related to contributing factors, root cause of the incident, comments or corrective action to prevent recurrence, and date corrective actions were implemented; however, the investigation section was blank.

Two of the pharmacy-related medication incidents were related to delivery issues and availability of a medication which lead to a resident not receiving their medication as prescribed. The third pharmacy-related medication incident was pertaining to the wrong directions written by pharmacy on a resident's medication.

The acting Director of Care (DOC) identified that the review, analysis, and corrective actions were not completed for the nursing-related medication incident.

The Consultant Pharmacist identified medication incidents were submitted to the pharmacy via the Medication Incident Reporting System (MIRS) and that when it was reported, there was a nursing review portion completed by the home, and once this was completed, the pharmacy conducted their review including

identifying and implementing corrective actions. They verified that the review, analysis, and implementation of corrective actions for the pharmacy-related medication incidents were not completed, as the home had not completed the nursing review portion.

There was a high risk of recurrence of medication incidents as the home did not review and analyze medication incidents that were reported, including identifying root causes and contributing factors to the incidents. Thus, the safety of residents was at high risk related to medication management.

Sources: The home's Medication Incident Reports for 2021; interview with the Consultant Pharmacist and Acting Director of Care.

An order was made by taking the following factors into account:

Severity: There was minimal risk of recurrence of medication incidents, as the home did not review and analyze medication incidents. This placed the safety of residents at risk related to medication management.

Scope: This was a widespread issue as four medication incidents reported in 2021, did not have a review, analysis, and implementation of corrective actions.

Compliance History: 32 written notification (WN), 14 voluntary plans of correction (VPC), and six compliance orders (CO) were issued to the home related to different sections of the legislation in the past 36 months. (748)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 02, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions;
(b) any changes and improvements identified in the review are implemented; and

(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Order / Ordre :

The licensee must comply with section 135 (3) of Ontario Regulation 79/10.

Specifically, the licensee shall ensure that:
1. A quarterly evaluation of medication incidents is completed, in order to reduce and prevent medication incidents.

Grounds / Motifs :

1. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home to reduce and prevent medication incidents.

Four medication incidents were reported in 2021. Three were pharmacy-related pertaining to an error in dispensing, and labelling of medications, and one was nursing-related pertaining to an error in administration of a medication.

The nursing-related medication incident identified that a previous dose of a medication was reduced. It was identified that an extra tablet of the medication was given to the resident when a RN discovered that the discontinued blister pack contained the wrong count. The RN confirmed with the RPN who worked at the time of the incident, that an extra dose was given to the resident.

Two of the pharmacy-related medication incidents were related to delivery issues and availability of a medication which lead to a resident not receiving their medication as prescribed. The third pharmacy-related medication incident was pertaining to the wrong directions written by pharmacy on a resident's medication.

The home's Medication Incident and Reporting policy stated to review all medication incidents, adverse drug events, and corrective action plans at the home's Medical/Professional Advisory Committee.

The Consultant Pharmacist identified that they had not participated in a quarterly review of all medication incidents that have occurred in the home, in order to reduce and prevent medication incidents.

The Administrator identified that a quarterly review of all medication incidents to reduce and prevent medication incidents, was not completed for 2020 including the first quarter of 2021.

There was a risk that necessary changes and improvements to prevent medication incidents would not be implemented, as a review of the medication incidents in the home, which included errors in dispensing, labelling, and administration of medications, were not being conducted quarterly. This posed a risk to the safety of residents related to medication management.

Sources: The home's Medication Incident Reports for 2021, and Medication Incident and Reporting policy; interview with the Consultant Pharmacist, and the Administrator.

An order was made by taking the following factors into account:

Severity: There was a minimal risk that necessary changes and improvements to prevent medication incidents would not be implemented, as the home did not complete a quarterly review of medication incidents.

Scope: The home did not complete a quarterly review of medication incidents in 2020, and 2021, which was at least five quarterly reviews not completed.

Compliance History: 32 written notification (WN), 14 voluntary plans of correction (VPC), and six compliance orders (CO) were issued to the home related to different sections of the legislation in the past 36 months. (748)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 02, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 1st day of June, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Bos

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