Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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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 28, 2019	2019_793743_0008	010502-17, 011197-17, 031620-18, 002556-19, 002557-19, 002558-19, 003906-19, 008618-19	Complaint

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Arthur Nursing Home
215 Eliza Street P.O. Box 700 ARTHUR ON N0G 1A0

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

KIYOMI KORNETSKY (743), JANET GROUX (606), KRISTAL PITTER (735), NUZHAT UDDIN (532)

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): May 14-17, 21-24, 27-31 and June 3-6, 2019.

Log #010502-17, related to concerns that a resident was refused a bed due to their use of medical marijuana.
Log #003906-19, related to concerns about staffing, care standards, maintenance, laundry and housekeeping.
Log #008618-19, related to concerns that staff neglect contributed to the death of a resident, as well as concerns about two other unexpected resident deaths.
Log #011197-17, related to concerns about and the care interventions provided to a resident with responsive behaviors.

PLEASE NOTE: Written Notifications and Compliance Orders related to O.Reg. 79/10, s.8(1) and O.Reg.79/10, s.131(2), as well as a Written Notification and Voluntary Plan of Correction, related to O.Reg. s.50(2)(b)(IV), were identified in a concurrent inspection # 2019_793743_0009 (Log #010251, Log #031073, and Log #004111-19) were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director or Care (DOC), the Assistant Director of Care (ADOC), the Resident Assessment Instrument Coordinator (RAI-C), the Ward Clerk (WC), the Behavioral Supports Ontario (BSO), Registered Practical Nurses (RPN), Registered Nurses (RN), Personal Support Workers (PSW), and Housekeeping.

The inspector(s) reviewed clinical records, plans of care for relevant residents, pertinent policies and procedures, the home's documentation related to relevant investigations, employee files, completed observations and interviewed residents and staff.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 52. (2)	CO #001	2018_750539_0008	743

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee failed to ensure that staff used safe transferring and positioning devices when assisting residents.

A complaint was submitted to the MOHLTC and reported that resident #017 fell out of a device during a transfer because the battery on the device was not charged.

The complainant told the inspector that resident #017 fell because of a malfunction with the device.

Maintenance Staff #137 stated that the device that resident #017 was on tipped, because the battery did not have enough charge.

Personal Support Workers (PSWs) #130, #119, #120, and Maintenance staff #137 stated that the devices were checked nightly by staff to ensure that the devices were in proper safe and working condition. PSWs stated that a checklist was completed and signed after the devices were checked.

The inspection checklists for one of the units was reviewed and showed a number of shifts where the devices were not checked.

The ADOC acknowledged that the home's staff did not implement the device inspections for a number of shifts.

The licensee failed to ensure that staff used a safe transferring and positioning device while assisting resident #017, when they used a device that did not have a fully charged battery, which prevented it from remaining steady and resulted in it tipping over.

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. 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 :

A) The licensee has failed to comply with compliance order (CO) #001 from inspection 2018_739694_0022 issued on January 25, 2019, with a compliance due date of February 5, 2019.

The licensee was ordered to be compliant with O. Reg. 79/10, s. 8(1). Specifically, the licensee was to ensure:

1) All registered staff receive education related to the home's medication management policies and procedures, and a record was to be kept of the staff that received education.

2) All registered staff were to comply with all aspects of the medication management program, which would include the development and implementation of a quality improvement process to ensure registered staff were compliant with processing orders and high alert/ narcotic administration policies and procedures. The licensee completed step one in CO #001.

The licensee failed to complete step two, including the development and implementation of a quality improvement process to ensure registered staff were compliant with processing orders and high alert/ narcotic administration policies and procedures.

In accordance with O. Reg. 79/10, s. 114 (1), the licensee was required to provide an interdisciplinary medication management system that provided safe medication management and optimized effective drug therapy outcomes.

a) The Home's policy and procedure entitled "High Alert Medication" number 5-7 dated February 2017, and revised date June 2018; directed that residents on high-alert

medications were to be identified, in order to alert staff administering medications to these residents. One method of identifying these residents was to place a high alert label on the spine of the resident's chart.

On May 17, 2019, during Cedar unit observations with Assistance Director of Care (ADOC) #102, it was noted that high alert labels were not placed on the chart binder spines.

b) The Home's policy and procedure entitled "High Alert Medication" number 5-7 dated February 2017, and revised June 2018; stated under procedure to administer high alert medications with caution. Staff were to thoroughly and carefully double check the medication to be administered to the resident, by reading the drug information and order on the Medication Administration Record (MAR), against the medication label, as well administering the medication as per the College of Nurses guidelines.

Medication errors over a period of three months were reviewed.

A Medication incident report stated resident #005 was to receive a medication twice daily at 0600 and 1800 hours. The medication incident report indicated that a dose of the medication was found on top of resident #005's mattress. The resident was known to pocket food and medication in their mouth and spit it out later. The medication card had evidence that the medication was signed out by the RN everyday at 0600 hours.

A second medication incident report stated that the evening RPN noted that the 1700 hours medication for resident #010 had been administered at 1400 hours. Resident #010 was to receive the medication three times daily at 0800, 1200 and 1700 hours, and it was not to be given at 1400 hours. The medication incident report further stated that the medication was held at 1700 hours and would be given at bedtime as prescribed.

A third medication incident report stated that resident #011 was to receive a medication daily at 0800 and at 1700 hours. The medication incident reported that the nurse did not administer resident #011's 0800 hour medication, even though they signed that it was given on the Electronic Medication Record (eMAR). The Medication incident stated that the medication was found in the card for resident #011. The report also indicated that the nurse was to do a thorough count of the medication cart after the medication pass, and not sign for medications until the medication had been given.

The Home's policy and procedure entitled "High Alert Medication" was reviewed with the

DOC #101. DOC #101 acknowledged that if staff had double checked the medications and administered the medication as per CNO guidelines, the errors would not have occurred.

c) The quality improvement process was reviewed, and it was noted that the “narcotic and controlled medication audit” and the “medication administration audit”, did not include identifying residents on high-alert medications, alerting all staff administering medication to these residents; and it also did not include auditing the labels placed on the chart, medication bins, MARS, and medications themselves.

ADOC #102 said that the controlled medication audit was completed by the pharmacist to ensure the storage of medication met the legal and facility standards. The controlled medication audit, however, did not include auditing high alert stickers, posting of information about high alert medications, the administration of high alert medications or independent double checks (IDC) for antineoplastic and methoxyarene injectable medications.

The licensee has failed to ensure that the home's policy on High Alert Medication was complied with. (532)

B) The licensee 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, policy; the licensee was required to ensure that the policy was complied with.

In accordance with O.Reg.79/10, s.49 (2), the licensee must ensure that when a resident has fallen, the resident is assessed, and a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Specifically, staff did not comply with the licensee's “Head Injury Routine Policy”, last revised May 2018, which stated that immediately after a resident sustained an unwitnessed fall, the Registered Nurse in charge was to assess the resident using the Glasgow Coma Scale.

A Facility head injury routine (HIR) was also to be followed as per the policy and procedure, unless otherwise stated by the Attending Physician. This facility HIR should have been completed every half hour for the first two hours following injury, every hour the next four hours, every four hours for the next eight hours, and every shift for the

remainder of the 72-hour monitoring.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) with concerns related to resident #017's fall during a transfer.

Resident #017 told the Inspector that they fell while being transferred.

Resident #017's progress notes stated that the resident was assessed by a registered staff and a HIR was initiated.

The HIR showed that the resident was monitored at 0745hrs, 0830hrs, 0900hrs, 0930hrs, 1030hrs, 1130hrs, 1230hrs, 1330hrs, 1730hrs, and 2330hrs. The HIR was not completed on the following day or night shift, thus resident #017 was not assessed every shift for the remainder of the 72-hour monitoring period.

DOC #101 stated that the expectation for registered staff was to follow the home's HIR policy.

C) A CI was submitted to the MOHLTC related to an unwitnessed fall and subsequent transfer of resident #019 to hospital.

RN #122 documented in the progress notes that resident #019 was found lying on the floor beside their bed. The fall was unwitnessed, and an assessment of resident #019 using the Glascow Coma Scale could not be found.

DOC#101 said that staff were directed to start a Head Injury Routine if a resident had an unwitnessed fall; and that they could not find a completed Head Injury Routine Assessment for resident #019 after their unwitnessed fall.

The licensee failed to ensure that the Home’s “Head Injury Routine Policy” last revised May, 2018, was complied with; when they failed to assess residents #017 and #019 using the Glascow Coma Scale. (743)

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

A) The licensee has failed to comply with compliance order (CO) #002 from inspection 2018_739694_0022 issued on January 25, 2019, with a compliance due date of February 19, 2019.

The licensee was ordered to be compliant with s.8(3) of the LTCHA.

Specifically, the licensee was to ensure that at least one Registered Nurse (RN) who is both an employee of the licensee and a member of the regular nursing staff of the home is always on duty and present in the home, except as provided for in the regulations.

A four-month period of documentation was reviewed, which included the home's staffing plan, staffing schedules, registered staff shift replacement information, agency invoice statements and daily roster sheets. The review focused on the period between February 19, 2019 and May 19, 2019.

During that time 23% of shifts did not have a Registered Nurse (RN) on duty who was both an employee of the licensee and a member of the regular nursing staff.

Executive Director (ED) #100 said when there was an agency staff in the home the DOC or the ADOC would be on call, if they were not present in the home; however, they acknowledged that agency staff were not employees of the licensee.

The licensee failed to ensure that they had an RN who was both an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at all times. (532)

B) A complaint was submitted to MOHLTC reporting concerns about staffing and resident #008's care.

The complainant told the Inspector that they were concerned that the Charge Nurse who worked the night shift on a specific date, was from a nursing agency and alleged that the nurse was not sure of the home's practices. They stated that resident #008 had a change in their condition and said the Charge Nurse who attended the resident had problems providing treatment, because they did not know where the supplies were located.

The home's staffing complement confirmed that Agency RN #136 was the only registered staff who worked the night shift on that specific date.

Agency RN #136 stated that they were assigned to be the Charge Nurse of the Building on that specific date, and that they were the only registered staff who worked that night.

ADOC #102 stated they were on call on that date, and assisted Agency RN #136 during the shift. They also confirmed that Agency RN #136 worked the night shift without a registered staff member of the home present.

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. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to comply with compliance order (CO) #003 from inspection 2018_739694_0022 issued on January 25, 2019, with a compliance due date of February 5, 2019.

The licensee was ordered to be compliant with O. Reg. 79/10, s. 131 (2). Specifically, the licensee was to ensure:

1) All registered staff receive education of the policies and procedures related to narcotic administration, as well as high alert medications, and the expectations when obtaining physician orders and administration.
2) Registered staff receive education on the calculation and administration of sub-cutaneous morphine.
3) Registered staff receive education on the independent and/or double-check system.

The licensee completed steps one to three, however, in accordance with O. Reg. 79/10, s.131(2), the licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #021 was prescribed a medication on a specific date and did not receive their first dose of the medication until six days later.

A record review was completed in PCC, as well as in the resident’s paper chart. Documentation in the progress notes indicated that resident #021 exhibited behaviors towards resident #027. One of the interventions put in place to address the resident’s responsive behaviors was to increase their dose of a medication.

ADOC #102 transcribed a telephone order from the physician ordering that resident #021’s medication dose be increased. Review of the resident’s electronic medication record (eMar), indicated that the increased dose of the medication, was added five days after the prescribed order, and resident #021 received their first dose six days after the order was written.

Pharmacist #126 from Medical Pharmacies said they received the new order for the increased dose of medication; and that they sent a six-day supply of the medication to the Home the next day.

DOC #101 said that resident #021 did not receive the increased dose of medication over a five-day period.

The licensee failed to ensure that resident #021 received their prescribed dose of medication as prescribed by the resident's physician; when they failed to administer the medication over a five-day period.

Additional Required Actions:

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

WN #5: 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 :

The licensee has failed to ensure that a resident exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) A complaint submitted to the MOHLTC reported concerns regarding resident#012's

care.

The complainant told the inspector that they observed a number of areas of altered skin integrity on resident #012.

Resident #012's Head to Toe Assessment, stated that the resident was identified with areas of altered skin intergriy on their body.

DOC #101 and ADOC #102, acknowledged that if a resident had altered skin integrity, weekly skin and wound assessments were to be completed every seven days until the altered skin had resolved. Registered staff were to document the assessment using the Skin and Wound Evaluation in PCC.

Further review of resident #012's Point Click Care (PCC) assessments did not show that any reassessment of the marks were completed as required.

B) A CI submitted to the MOHLTC reported that resident#020 had sustained an injury and the wound was not reassessed weekly by a member of the registered nursing staff.

Documentation in the PCC progress notes indicated that resident #020 sustained a witnessed fall that resulted in a wound.

DOC #101 and ADOC #102, acknowledged that if a resident had altered skin integrity, weekly skin and wound reassessments were to be completed every seven days until the altered skin had resolved. Registered staff were to document the reassessment using the Skin and Wound Evaluation in PCC.

On a specific date, a skin and wound reassessment was completed of resident #020’s wound. The wound was documented as improving, but not yet resolved.

Review of the resident #020’s assessments completed in PCC, as well as in the progress notes, showed that the resident did not receive a skin and wound reassessment by a registered staff for the next four weeks.

The licensee failed to ensure that resident #012 and resident #020, who both exhibited altered skin integrity, were reassessed at least weekly by a member of the registered staff.

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 exhibiting altered skin integrity is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

The licensee failed to ensure that all registered staff received orientation training before performing their responsibilities, including the licensee's policies that were relevant to the staff's responsibilities, and any other areas provided for in the Regulation.

A complaint submitted to the MOHLTC reported concerns regarding the home's staffing.

The complainant told the Inspector that the registered staff working on a specific date, was from an agency and alleged the RN had not worked in the home before.

Agency RN #136 told the Inspector that on that specific day, it was first time they had worked at the home and stated that they were not provided orientation. Agency RN #136 also revealed that after that day, they worked two other times and did not receive orientation prior to working those shifts.

DOC #101 stated that Agency RN #136 did not receive orientation prior to working on a specific date, nor prior to the two shifts they worked after that date.

The licensee has failed to ensure that staff were not to perform their responsibilities prior to receiving training; when Agency RN #136 worked without any previous orientation or training.

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 person performs their responsibilities before receiving training as required,, to be implemented voluntarily.

Issued on this 5th day of July, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KIYOMI KORNETSKY (743), JANET GROUX (606), KRISTAL PITTER (735), NUZHAT UDDIN (532)
Inspection No. / No de l'inspection :	2019_793743_0008
Log No. / No de registre :	010502-17, 011197-17, 031620-18, 002556-19, 002557-19, 002558-19, 003906-19, 008618-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 28, 2019
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Arthur Nursing Home 215 Eliza Street, P.O. Box 700, ARTHUR, ON, N0G-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lindsay Ross

To Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with s.36 of O.Reg 79/10.

Specifically, the licensee must:

1) Ensure that all mechanical lift batteries are fully charged prior to their use.

Grounds / Motifs :

1. The licensee failed to ensure that staff used safe transferring and positioning devices when assisting residents.

A complaint was submitted to the MOHLTC and reported that resident #017 fell out of a device during a transfer because the battery on the device was not charged.

The complainant told the inspector that resident #017 fell because of a malfunction with the device.

Maintenance Staff #137 stated that the device that resident #017 was on tipped, because the battery did not have enough charge.

Personal Support Workers (PSWs) #130, #119, #120, and Maintenance staff #137 stated that the devices were checked nightly by staff to ensure that the devices were in proper safe and working condition. PSWs stated that a checklist was completed and signed after the devices were checked.

The inspection checklists for one of the units was reviewed and showed a number of shifts where the devices were not checked.

The ADOC acknowledged that the home's staff did not implement the device inspections for a number of shifts.

The licensee failed to ensure that staff used a safe transferring and positioning device while assisting resident #017, when they used a device that did not have a fully charged battery, which prevented it from remaining steady and resulted in it tipping over.

The severity level of this issue was determined to be a level 2, as there was minimal harm to the resident. The scope of the issue was a level 3 as it related to three out of three lift machines. The home had a level 3 compliance history as there was previous non-compliance to the same subsection that included:

- Voluntary Plan of Correction (VPC) issued on November 29, 2018 (2018_750539_0007).

(743)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 19, 2019

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2018_739694_0022, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.8(1) of O.Reg 79/10.

Specifically, the licensee must:

1) Ensure that the licensee and registered staff comply with all aspects of the medication management program and the licensee's policies related to high alert medication.

2) Develop and fully implement a quality improvement process that includes audits to ensure all registered staff are compliant with high alert/narcotic administration policies, procedures for processing these orders; and that the licensee is compliant with all aspects of their high alert medication policies.

3) Ensure that registered staff comply with all aspects of the licensee's head injury routine policy.

Grounds / Motifs :

1. A) The licensee has failed to comply with compliance order (CO) #001 from inspection 2018_739694_0022 issued on January 25, 2019, with a compliance due date of February 5, 2019.

The licensee was ordered to be compliant with O. Reg. 79/10, s. 8(1). Specifically, the licensee was to ensure:

1) All registered staff receive education related to the home's medication management policies and procedures, and a record was to be kept of the staff that received education.

2) All registered staff were to comply with all aspects of the medication management program, which would include the development and implementation of a quality improvement process to ensure registered staff were compliant with processing orders and high alert/ narcotic administration policies and procedures. The licensee completed step one in CO #001.

The licensee failed to complete step two, including the development and implementation of a quality improvement process to ensure registered staff were compliant with processing orders and high alert/ narcotic administration policies and procedures.

In accordance with O. Reg. 79/10, s. 114 (1), the licensee was required to provide an interdisciplinary medication management system that provided safe medication management and optimized effective drug therapy outcomes.

a) The Home's policy and procedure entitled "High Alert Medication" number 5-7 dated February 2017, and revised date June 2018; directed that residents on high-alert medications were to be identified, in order to alert staff administering medications to these residents. One method of identifying these residents was to place a high alert label on the spine of the resident's chart.

On May 17, 2019, during Cedar unit observations with Assistance Director of Care (ADOC) #102, it was noted that high alert labels were not placed on the chart binder spines.

b) The Home's policy and procedure entitled "High Alert Medication" number 5-7 dated February 2017, and revised June 2018; stated under procedure to administer high alert medications with caution. Staff were to thoroughly and carefully double check the medication to be administered to the resident, by reading the drug information and order on the Medication Administration Record

(MAR), against the medication label, as well administering the medication as per the College of Nurses guidelines.

Medication errors over a period of three months were reviewed.

A Medication incident report stated resident #005 was to receive a medication twice daily at 0600 and 1800 hours. The medication incident report indicated that a dose of the medication was found on top of resident #005's mattress. The resident was known to pocket food and medication in their mouth and spit it out later. The medication card had evidence that the medication was signed out by the RN everyday at 0600 hours.

A second medication incident report stated that the evening RPN noted that the 1700 hours medication for resident #010 had been administered at 1400 hours. Resident #010 was to receive the medication three times daily at 0800, 1200 and 1700 hours, and it was not to be given at 1400 hours. The medication incident report further stated that the medication was held at 1700 hours and would be given at bedtime as prescribed.

A third medication incident report stated that resident #011 was to receive a medication daily at 0800 and at 1700 hours. The medication incident reported that the nurse did not administer resident #011's 0800 hour medication, even though they signed that it was given on the Electronic Medication Record (eMAR). The Medication incident stated that the medication was found in the card for resident #011. The report also indicated that the nurse was to do a thorough count of the medication cart after the medication pass, and not sign for medications until the medication had been given.

The Home's policy and procedure entitled "High Alert Medication" was reviewed with the DOC #101. DOC #101 acknowledged that if staff had double checked the medications and administered the medication as per CNO guidelines, the errors would not have occurred.

c) The quality improvement process was reviewed, and it was noted that the "narcotic and controlled medication audit" and the "medication administration audit", did not include identifying residents on high-alert medications, alerting all staff administering medication to these residents; and it also did not include

auditing the labels placed on the chart, medication bins, MARS, and medications themselves.

ADOC #102 said that the controlled medication audit was completed by the pharmacist to ensure the storage of medication met the legal and facility standards. The controlled medication audit, however, did not include auditing high alert stickers, posting of information about high alert medications, the administration of high alert medications or independent double checks (IDC) for antineoplastic and methoxyarene injectable medications.

The licensee has failed to ensure that the home's policy on High Alert Medication was complied with. (532)

B) The licensee 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, policy; the licensee was required to ensure that the policy was complied with.

In accordance with O.Reg.79/10, s.49 (2), the licensee must ensure that when a resident has fallen, the resident is assessed, and a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Specifically, staff did not comply with the licensee's "Head Injury Routine Policy", last revised May 2018, which stated that immediately after a resident sustained an unwitnessed fall, the Registered Nurse in charge was to assess the resident using the Glasgow Coma Scale.

A Facility head injury routine (HIR) was also to be followed as per the policy and procedure, unless otherwise stated by the Attending Physician. This facility HIR should have been completed every half hour for the first two hours following injury, every hour the next four hours, every four hours for the next eight hours, and every shift for the remainder of the 72-hour monitoring.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) with concerns related to resident #017's fall during a transfer.

Resident #017 told the Inspector that they fell while being transferred.

Resident #017's progress notes stated that the resident was assessed by a registered staff and a HIR was initiated.

The HIR showed that the resident was monitored at 0745hrs, 0830hrs, 0900hrs, 0930hrs, 1030hrs, 1130hrs, 1230hrs, 1330hrs, 1730hrs, and 2330hrs. The HIR was not completed on the following day or night shift, thus resident #017 was not assessed every shift for the remainder of the 72-hour monitoring period.

DOC #101 stated that the expectation for registered staff was to follow the home's HIR policy.

C) A CI was submitted to the MOHLTC related to an unwitnessed fall and subsequent transfer of resident #019 to hospital.

RN #122 documented in the progress notes that resident #019 was found lying on the floor beside their bed. The fall was unwitnessed, and an assessment of resident #019 using the Glascow Coma Scale could not be found.

DOC#101 said that staff were directed to start a Head Injury Routine if a resident had an unwitnessed fall; and that they could not find a completed Head Injury Routine Assessment for resident #019 after their unwitnessed fall.

The licensee failed to ensure that the Home's "Head Injury Routine Policy" last revised May, 2018, was complied with; when they failed to assess residents #017 and #019 using the Glascow Coma Scale. (743)

The severity level of this issue was determined to be a level 2, as there was minimal harm to the resident. The scope of the issue was a level 2 as it related to two out of three residents. The home had a level 4 history of on-going non-compliance with this section of the Act that included:
-Compliance Order (CO) issued January 25, 2019 (2018_739694_0022).
(606)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 19, 2019

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2018_739694_0022, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be compliant with s.8(3) of the Long-Term Care Homes Act.

Specifically, the licensee must:

1) Ensure that at least one Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Grounds / Motifs :

1. A)A) The licensee has failed to comply with compliance order (CO) #002 from inspection 2018_739694_0022 issued on January 25, 2019, with a compliance due date of February 19, 2019.

The licensee was ordered to be compliant with s.8(3) of the LTCHA.

Specifically, the licensee was to ensure that at least one Registered Nurse (RN) who is both an employee of the licensee and a member of the regular nursing staff of the home is always on duty and present in the home, except as provided for in the regulations.

A four-month period of documentation was reviewed, which included the home's staffing plan, staffing schedules, registered staff shift replacement information, agency invoice statements and daily roster sheets. The review focused on the

period between February 19, 2019 and May 19, 2019.

During that time 23% of shifts did not have a Registered Nurse (RN) on duty who was both an employee of the licensee and a member of the regular nursing staff.

Executive Director (ED) #100 said when there was an agency staff in the home the DOC or the ADOC would be on call, if they were not present in the home; however, they acknowledged that agency staff were not employees of the licensee.

The licensee failed to ensure that they had an RN who was both an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at all times. (532)

B) A complaint was submitted to MOHLTC reporting concerns about staffing and resident #008's care.

The complainant told the Inspector that they were concerned that the Charge Nurse who worked the night shift on a specific date, was from a nursing agency and alleged that the nurse was not sure of the home's practices. They stated that resident #008 had a change in their condition and said the Charge Nurse who attended the resident had problems providing treatment, because they did not know where the supplies were located.

The home's staffing complement confirmed that Agency RN #136 was the only registered staff who worked the night shift on that specific date.

Agency RN #136 stated that they were assigned to be the Charge Nurse of the Building on that specific date, and that they were the only registered staff who worked that night.

ADOC #102 stated they were on call on that date, and assisted Agency RN #136 during the shift. They also confirmed that Agency RN #136 worked the night shift without a registered staff member of the home present.

The severity level of this issue was determined to be a level 2, as there was

minimal harm to the residents. The scope of the issue was a level 3 as widespread. The home had a level 4 history of on-going non-compliance with this section of the Act that included:
-Compliance Order (CO) issued January 25, 2019 (2018_739694_0022)
(606)
(606)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 01, 2020

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2018_739694_0022, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.131(2) of O.Reg.79/10.

Specifically, the licensee shall ensure:

1) All registered staff administer drugs to residents in accordance with the directions for use as specified by the prescriber.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order (CO) #003 from inspection 2018_739694_0022 issued on January 25, 2019, with a compliance due date of February 5, 2019.

The licensee was ordered to be compliant with O. Reg. 79/10, s. 131 (2). Specifically, the licensee was to ensure:

1) All registered staff receive education of the policies and procedures related to narcotic administration, as well as high alert medications, and the expectations when obtaining physician orders and administration.
2) Registered staff receive education on the calculation and administration of sub-cutaneous morphine.
3) Registered staff receive education on the independent and/or double-check system.

The licensee completed steps one to three, however, in accordance with O. Reg. 79/10, s.131(2), the licensee failed to ensure that drugs were administered to

residents in accordance with the directions for use specified by the prescriber.

Resident #021 was prescribed a medication on a specific date and did not receive their first dose of the medication until six days later.

A record review was completed in PCC, as well as in the resident's paper chart. Documentation in the progress notes indicated that resident #021 exhibited behaviors towards resident #027. One of the interventions put in place to address the resident's responsive behaviors was to increase their dose of a medication.

ADOC #102 transcribed a telephone order from the physician ordering that resident #021's medication dose be increased. Review of the resident's electronic medication record (eMar), indicated that the increased dose of the medication, was added five days after the prescribed order, and resident #021 received their first dose six days after the order was written.

Pharmacist #126 from Medical Pharmacies said they received the new order for the increased dose of medication; and that they sent a six-day supply of the medication to the Home the next day.

DOC #101 said that resident #021 did not receive the increased dose of medication over a five-day period.

The licensee failed to ensure that resident #021 received their prescribed dose of medication as prescribed by the resident's physician; when they failed to administer the medication over a five-day period.

The severity level of this issue was determined to be a level 2, as there was minimal harm to the residents. The scope of the issue was a level 1 as it related to one out of three residents. The home had a level 4 history of on-going non-compliance with this section of the Act that included:
-Compliance Order (CO) issued January 25, 2019 (2018_739694_0022)
(743)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 19, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 28th day of June, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Kiyomi Kornetsky

Service Area Office / Bureau régional de services : Central West Service Area Office