Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 8, 2019	2019_722630_0010	027851-18, 030268-18, 031190-18, 003057-19, 006769-19	Critical Incident System

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 on Bonnie Place
15 Bonnie Place St Thomas ON N5R 5T8

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

AMIE GIBBS-WARD (630), JULIE LAMPMAN (522)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 17, 23, 24, 25, 26 and 29, 2019.

The following Critical Incident intakes were completed within this inspection:

Related to the prevention of abuse and neglect:
Critical Incident Log #027851-18 / CI 2730-000022-18
Critical Incident Log #030268-18 / CI 2730-000029-18
Critical Incident Log #006769-19 / CI 2730-000010-19

Related to medication administration:
Critical Incident Log #003057-19 / CI 2730-000005-19

Related to an unexpected death of a resident:
Critical Incident Log #031190-18 / CI 2730-000031-18

During the course of the inspection, the inspector(s) spoke with the Caressant Care Regional Director Long-Term Care, the Executive Director (ED), the Director of Care (DOC), a Resident Care Coordinator (RCC), a Resident Assessment Instrument (RAI) Co-ordinator, the Nutrition Manager, the Clinical Consultant Pharmacist, a Physician, a Ward Clerk, the Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN), Registered Nurses (RN), RPNs, Personal Support Workers (PSWs) and residents.

The inspectors also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed various meeting minutes and reviewed written records of program evaluations.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **7 WN(s)**
- **4 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The definition of emotional abuse in Section 2(1) of the Ontario Regulation 79/10 includes "action or behaviour performed by anybody except by a resident including any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization."

The definition of verbal abuse in Section 2(1) of the Ontario Regulation 79/10 includes "any form of verbal communication of a belittling or degrading nature which may diminish the resident's sense of well-being, dignity or self worth made by anyone other than a resident."

The staff in the home failed to comply with the written policy titled "Abuse and Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" with effective date August 2018. This policy stated "abuse, in any form, is a direct violation of the intrinsic right and will not be tolerated." This policy also stated "residents, families and staff must report all situations of suspected or actual abuse to the Executive Director and/or Director of Care, this includes suspicion of abuse of a resident while out on a leave of absence."

This policy included a section titled "Reporting" which stated the following:
- "1. All cases of suspected or actual abuse must be immediately reported to the DOC/Executive Director."
- "2. After receiving notice of the abuse, the DOC/Manager on call will immediately notify the Executive Director of the initiation of an investigation."

This policy also included a section titled "Investigating and Responding to Alleges, Suspected or Witnessed Abuse or Neglect of Resident" with a subsection "Family to Resident Abuse" which stated the following:
- "1. Any staff witnessing an allegation/actual act of abuse (or has reason to believe that an act of abuse occurred while the resident was on a leave of absence) must report it as outlined to their immediate supervisor."
- "2. The supervisor will ensure that the immediate needs of the resident are attended to."
- "4. The DOC/Executive Director will meet with the family to discuss the alleged/actual abuse. The family member should be advised of his/her right to have representation of their choice present during the interview with the DOC/Executive Director and/or police, if

applicable."
- "7. A Ministry of Health Critical Incident Summary must be completed."

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-term Care (MOHLTC) related to an incident involving an identified resident and an identified visitor.

During an interview the Executive Director (ED) told Inspector #630 that they were familiar with this CIS report and this resident. The ED said the home had investigated the incident in a specific way and at the time they had not identified this incident as an allegation of abuse.

During interviews with identified staff members they reported they were familiar with this identified resident. The staff expressed that they were aware of concerns related to the way an identified visitor treated the resident on multiple occasions while in the home.

During an interview the Resident Care Coordinator (RCC) told Inspector #630 that the home's program on prevention of abuse and neglect covered visitor to resident abuse but this part of the policy was not as broad as resident to resident or staff to resident abuse. The RCC said they were familiar with this resident and that they had been the manager on-call who submitted the CIS report to the MOHLTC. RCC said they had taken specific actions to investigate the incident. The RCC said that at the time it did not occur to them that this was an incident of visitor to resident abuse, but in retrospect it seemed like it could fit into that category. The RCC said they were not personally involved in any follow-up about this incident. The RCC reviewed the progress notes for this resident and acknowledged there was a documented allegation of visitor to resident abuse on another specific date. When asked if staff identified concerns with how the visitor was treating this resident, the RCC said "always".

The clinical record for this identified resident included documentation on the date of the CIS report which indicated the resident's condition included being "upset." The clinical record also included progress notes documented by various staff regarding concerns with the way this specific visitor was treating this resident. The progress notes described specific actions that had been taken by the staff and management in the home.

During a follow-up interview, the Executive Director (ED) told Inspector #630 that the home's policy on prevention of abuse and neglect did cover family or visitor to resident abuse. The ED said that the policy indicated that the consequences for visitors or family

members who were found to have abused a resident was that they would talk to the family or the Power of Attorney and included no further direction. When asked if the policy included how to support residents who had been affected by visitor or family to resident abuse, the ED said that it directed that the immediate needs of the resident were to be attended and you would contact the family. When asked if based on a review of this CIS report for this identified resident whether this should have been immediately investigated as an incident of alleged visitor to resident emotional abuse, the ED said that looking back they should have done a CIS report for alleged abuse. The ED acknowledged to Inspector #630 that this incident was not investigated as abuse. When asked if there were any concerns with the way this visitor treated the resident when visiting in the home, the ED described specific concerns and the actions taken in the home. The ED said that they did not think that a specific documented incident was reported to the Director of Care (DOC) or ED as an allegation of abuse at the time and based on the policy staff should have reported this allegation. The ED said this was not investigated as an allegation of abuse and it was not reported to the MOHLTC.

The home has failed to ensure that the written policy to promote zero tolerance of emotional and verbal abuse of residents by visitors was complied with. Based on the CIS report, interviews with staff and management as well as a review of the resident's clinical records, there were multiple reported and observed incidents of alleged abuse by a specific visitor towards this resident. The staff in the home failed to report these incidents immediately to the management in the home, the management in the home did not immediately investigate the allegations of abuse, the management in the home did not take immediate action to protect the resident from further incidents of visitor to resident abuse, the staff or management in the home did not take actions to determine what the "immediate needs" of the resident were after the incidents of visitor to resident abuse to determine what victim supports were needed, the management did not meet with the accused family member to discuss the allegations and the staff and management in the home did not notify the MOHLTC of the allegations of abuse. (630) [s. 20. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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 :

The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including a monthly audit undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) related to a missing/unaccounted controlled substance.
A review of the CIS report by Inspector #522 noted during the narcotic count on a specific date and time two staff members completed the narcotic count and were unable to account for a specific medication for an identified resident.

A review of the 'Shift Change Monitored Medication Count' for C Wing for specific time periods, noted the count showed this identified resident had a specific number of the medication remaining and in one instance one number was written in bold over another number. Inspector #522 was unable to determine when the change was made and who made the change as there were no initials beside the change.

During an interview an identified staff member said they had documented the count for this area on this specific date. The staff said normally when an error was made they would cross out the error and initial the change and have the other staff member who

completed the count initial the change also. The staff member could not recall why they did not do this when they changed the count for this identified resident.

Further review of the 'Shift Change Monitored Medication Count' for another specific time period noted 10 entries where the numbers had been changed on the 'Shift Change Monitored Medication Count' sheet, seven of the entries were illegible. Inspector #522 was unable to determine when the changes were made and who made the changes as there were no initials beside the numbers that had been changed.

During an interview with another staff member they stated they had documented the count on a specific date. When asked about four entries that had been changed on the count, three of which were illegible, the staff member stated they could not recall why the numbers on the count were changed. The staff member stated normally when they made an error in the count they would cross the error out with a line and initial the change.

During another interview with another identified staff member they described the process for completing the count on a specific date. When asked about four of the entries that had been changed on the count the staff member reviewed the count sheet and acknowledged the numbers on the count were difficult to read. The staff member stated they really could not remember what exactly happened and when they made a correction on the count they usually initialled it. When asked about the changes made to an identified resident's count on a specific date, the staff member stated they thought they might have followed what was above on the count and then realized the counts were accidentally in the wrong box and fixed it. The staff member acknowledged they did not initial that they had made changes to the counts.

A review of the 'Shift Change Monitored Medication Count' sheets for a specific date with two other identified staff noted that the entire box had been scratched out for the count on a specific date for a specific medication. The entry below had a 'one' and then another number that had been scratched out which was illegible. The staff stated that those were their errors, and that they wrote the wrong number in the box and it should have been in the next box. The staff stated they had initialled above the 1500 hours count.

In an interview, the Resident Care Coordinator (RCC) reviewed the 'Shift Change Monitored Medication Count' for specific dates. The RCC acknowledged that there were counts that were illegible as numbers had been changed and written over top of each other. The RCC stated the 'Shift Change Monitored Medication Count' sheets were

reviewed and audited monthly. The RCC stated the audits were completed by the Director of Care (DOC).

Review of Medical Pharmacies "Shift Change Monitored Drug Count" policy 6-6 with a revision date of November 2018, noted a 'Narcotic/Controlled Drugs Monthly Audit' form which stated the following: "This form is used to audit the daily count sheets of narcotic/controlled drugs monthly. After completion, unmet(s) are to be addressed with action plans. Store completed audits in Director's office for 3 years." The form in part, included audits that the physical quantity of drug matched the count on the individual count and shift count sheets, that shift count was completed by two nurses, shift count sheets were not pre-signed and no corrections or changes were made to previous counts. The policy also stated that monthly audits were to be tracked using the 'Narcotic/Controlled Drugs Audit Annual Tracking' form.

During an interview the Caressant Care Regional Director Long-Term Care (RDLTC) told Inspector #522 if registered staff had made a change to the Monitored Drug Count sheet they would be expected to initial the change and correct the error to ensure the count was correct. The RDLTC stated the monthly audits of the 'Shift Change Monitored Medication Count' sheets would be completed by the DOC and would be in the DOC's office.

During another interview the RCC and Director of Care (DOC) stated they were unable to find any completed 'Narcotic/Controlled Drugs Monthly Audit' forms for January to March 2019. The DOC provided Inspector #522 the 'Narcotic/Controlled Drugs Audit Annual Tracking' form which noted an audit was completed on March 25, 2019 for January and February 2019.

Review of the 'Narcotic/Controlled Drugs Audit Annual Tracking' form for February 2019 for C Wing noted there were six missing signatures on the count sheets and discrepancies were identified. The 'Narcotic/Controlled Drugs Audit Annual Tracking' form for February 2019 for B Wing noted there were two missing signatures and discrepancies were identified.

In a follow-up interview the RDLTC said they had been the interim DOC from the later part of January, February and March 2019. The RDLTC stated they had completed the 'Narcotic/Controlled Drugs Audit Annual Tracking' form on March 25, 2019, for January and February 2019. The RDLTC stated when they had noted there were discrepancies that was to indicate there were missing signatures on the 'Shift Change Monitored Drug

Count' sheets. The RDLTC stated they had completed the 'Narcotic/Controlled Drugs Monthly Audit' forms but acknowledged that there was no documented evidence to support that the monthly audits were completed.

The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including a monthly audit undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered. (522) [s. 130. 3.]

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices and that the symptoms were recorded and immediate action was taken as required.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-term Care (MOHLTC) regarding an allegation of staff to resident neglect that the management of the home received. This CIS report stated an identified resident's family had reported specific concerns about the care provided to this resident.

During an interview this identified resident told Inspector #630 that they had experienced

a change in their health which involved a specific symptom during a specific time period.

The clinical record for this resident included documentation in the electronic Medication Administration Record (eMAR) for specific dates showing the resident had been given an as needed (PRN) dose of specific medications for a specific symptom. The only date vital signs, including temperature and oxygen saturation levels, were recorded in the "weight and vitals" section of PointClickCare (PCC) for this resident was on one specific date during a specific time period. There were no documented progress notes regarding signs or symptoms of infection, apart from the notes regarding the administration of as needed medication and the concern raised by the family, for a specific time period. There was a progress note by the nurse for a specific date which documented that the resident could have a specific type of infection and specific interventions were ordered. The home's outbreak line listing showed that this resident was added on a specific date with one symptom noted and no other symptoms documented. The line listing for this resident had no documentation for "temperature;" "prophylaxis/vaccination/treatment;" "complications" or "resolved date."

During an interview with an identified staff member they told Inspector #630 that the home had an infection prevention and control (IPAC) program in place and they recently had a specific type of outbreak in the home. The staff member said they would know which residents were considered to be symptomatic of an infection through the outbreak line listing. The staff member said they would document symptoms and vital signs in a progress note and at times, if a resident was in isolation, then it would be set up in the eMAR to automatically document vital signs. When asked what the process in the home was for monitoring residents for signs of infection, the staff member said they would monitor when doing vitals and ask the resident how they were feeling and that it would be documented in a progress note. The staff member said that they used the line listing to document at the onset of an infection but any new symptoms or the monitoring of symptoms would be documented in a progress note. The staff member said that they were familiar with this resident and this resident had requested as needed medication from them during a specific time period and the family had expressed concerns to them about a specific symptom.

The Executive Director (ED) provided Inspector #630 with a copy of the home's investigation documentation related to this CIS report and this documentation was reviewed as part of the inspection. There was no documented evidence in the investigation package to show that the symptoms of respiratory infection had been

monitored or documented by staff on each shift.

During an interview the Resident Care Coordinator (RCC) said they were the lead for the infection prevention and control (IPAC) program in home. The RCC said they recently had a specific type of outbreak in the home and Public Health was unable to determine the causative agent for the outbreak. The RCC said that staff would know which residents were considered to be symptomatic of the infection through the line listing as well as discussions at report. When asked what the process in the home was for monitoring residents for signs of respiratory infection, the RCC said that the registered staff would monitor when handing out the medication and the Personal Support Workers (PSWs) would monitor when doing care and then would report to the registered nursing staff. When asked what the process in the home was for documenting signs of respiratory infection, the RCC said they would expect to see a progress note each shift and it would be expected that this would include the monitoring of vital signs. When asked how they would know if a specific symptom had been monitored by staff during an outbreak, the RCC said that they would expect to see some sort of documentation or charting and if they did not see the documentation then there would be no way to know. The RCC said that the home had policies regarding outbreak management as part of the IPAC program, but these policies did not provide direction for staff related to the monitoring and documentation of symptoms. The RCC said they were familiar with this resident and based on the documentation in PCC the family brought forward concerns to staff about a specific symptom on a specific date. The RCC said that the next documentation regarding assessment of this symptom was a note by the nurse practioner seven days later. When asked if this resident was considered to be one of the cases for the outbreak, the RCC said that they were and the resident had been added to the line listing on a specific date. When asked if this resident had been having symptoms of this infection prior to that date, the RCC said that nothing had been reported to them.

The home's policy titled "Outbreak Control for Communicable Disease – Departmental Response During An Outbreak" with revised date April 2018, included that the "Nursing Staff (registered): investigates reported signs and symptoms; records pertinent information on the surveillance form." This policy did not provide any further direction regarding the monitoring or recording of symptoms of infection.

The home's policy titled "Outbreak Management" with revised date April 2018, included: "1. Review recent line list-initiate a separate line listing for ill resident and for staff." "2. Review symptoms to date-confirm if they are related to respiratory, enteric or influenza

outbreak." "5. Notify Public Health to receive further direction." This policy did not provide any further direction regarding the monitoring or recording of symptoms of infection.

The "Outbreak Control Measures Checklist" for Respiratory Outbreak with "Outbreak Status/Date Confirmed March 14, 2019" stated that the facility was to "monitor for new cases" and "track suspected and confirmed cases on an outbreak line listing." This checklist did not provide any further direction regarding the process for monitoring or recording of symptoms of infection.

During an interview the Executive Director (ED) told Inspector #630 that they were familiar with this resident and had been involved in investigating the allegations of neglect reported in the CIS report. The ED said that in response to the concern they had met with the staff, reviewed the eMAR for use of as needed medication and reviewed documentation. The ED said they were not sure when the resident's symptom had been added to the doctor's list for assessment. When asked if the home was in outbreak at the time of this concern, the ED said they could not recall. The ED said that this resident had been diagnosed with a specific condition and started on a specific type of medication.

B) During an interview with another staff member they told Inspector #630 that the home did have an IPAC program in place and the home recently had a specific type of outbreak which affected all areas of the home. The staff member said they would know which residents were considered to be symptomatic through verbal report, reading through the written shift report, from the line listing as well as based on reports from the PSW staff. When asked what staff were expected to do if a resident had a new symptom, the staff member said that if it was just one symptom they would monitor for 24 hours then if there was another symptom they would isolate them and add them to the line list. When asked what type of monitoring would be done, the staff member said it would include a chest assessment, full set of vitals including oxygen saturation and temperature and sometimes respiratory rates. When asked what the expectation was in the home regarding documentation of symptoms during an outbreak, the staff member said in the progress notes there should be a follow-up note and the vitals recorded in the vitals section of PCC. The staff member said they were familiar with an identified resident and this resident had two infections in a row in a specific time period. When asked what symptoms of infection this resident had shown, the staff member described four symptoms. The staff member said this resident had a specific type of test and had been diagnosed with a specific type of infection.

The clinical record for this resident included the documentation in the electronic Medication Administration Record (eMAR) for specific dates showing the resident had been given an as needed (PRN) dose of specific medications for a specific symptoms. The only date the resident's temperature was recorded in the "weight and vitals" section of PointClickCare (PCC) was on one specific date during a specific time period. The progress notes for a specific time period, included no documentation regarding the monitoring, assessing or recording of the resident's symptoms of infection for 25 out of 33 (76 per cent) of shifts. The progress notes for another specific time period, included no documentation regarding the monitoring, assessing or recording of the resident's symptoms of infection for 33 out of 36 (92 per cent) of shifts. The home's outbreak line listing showed that this resident was added on a specific date with three symptoms noted.

During an interview the RCC told Inspector #630 that they were familiar with this resident and this resident had been considered to be part of the home's recent outbreak. When asked when this resident was added to the outbreak line listing, the RCC said that it seemed confusing as this resident was not added until a specific date and they were not sure why the resident had not been added earlier. The RCC said it was the expectation in the home that staff would monitor for signs of respiratory infection on every shift and that the symptoms would be recorded in the progress notes.

C) During an interview with an identified staff member they said they were familiar with another identified resident and this resident had experience a change in their health. The staff member reviewed the progress notes for this resident and said that they had a specific type of infection and the home was in an outbreak at the time. The staff member said that the notes showed that the resident had specific symptoms and was started on a specific type of medication.

The clinical record for this resident included the documentation in the electronic Medication Administration Record (eMAR) for specific dates showing the resident had been given an as needed (PRN) dose of specific medications for specific symptoms. There were no progress notes documented for a specific time period. The home's outbreak line listing showed that this resident was added on a specific date with three symptoms noted.

During an interview the RCC told Inspector #630 that they were familiar with this resident and this resident had been considered to be part of the home's recent outbreak. The RCC said the resident had been added to the line listing on a specific date with specific

symptoms. The RCC reviewed the progress notes for this resident and said there was not any documentation of monitoring of the symptoms for a specific time period and it was the expectation that would have been done. The RCC acknowledged there was a delay in the initiation of the treatment as the specific medication was not contained in the home's emergency drug box and that the pharmacy indicated that they only did special deliveries of medications in emergency situations.

Based on interviews, record reviews and policy reviews, the licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in three identified resident were monitored in accordance with evidence-based practices, the symptoms were recorded and immediate actions were taken as required. (630) [s. 229. (5)]

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. 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 has failed to ensure that staff used safe transferring techniques when assisting residents.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-term Care (MOHLTC) regarding an incident on a specific date related to a transfer for an identified resident. The report documented that the resident required the use of a specific type of lift at the time and staff had instead used a different type of lift and the resident sustained an injury.

During an interview a specific staff member said that they would know what care a resident required for lifts and transfers from the plan of care as well as the logos posted on the closets in the residents' rooms. The staff member said they had received education in the home related to safe lifting and transferring practices. The staff member said they were familiar with this resident and this resident required a specific type of assistance from staff. The staff member said they recalled the incident and, along with another staff member, they had not used the correct type of lift when caring for this resident. The staff member said they felt badly right away after the incident. The staff member said that someone from the management team spoke with them about the incident.

The clinical record for this resident included a physiotherapy assessment on a specific date which documented the resident needed a specific type of assistance for transfers. The plan of care included a focus "requires assistance for transferring from one position to another" which was documented as having the intervention changed on a specific date to a specific type of transfer.

During an interview the Executive Director (ED) told Inspector #630 that they were involved in investigating the incident reported in this CIS. The ED said that based on the investigation the staff used the wrong type of lift and the resident sustained a specific injury. The ED said that both staff knew they were wrong, expressed that they knew what they were supposed to do and a specific type of disciplinary action was taken by the management in the home.

Based on the CIS report, interviews with staff and management and a review of clinical records, the staff in the home failed to use safe transferring techniques when assisting this resident on a specific date, which resulted in an injury to the resident. (630) [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-term Care (MOHLTC) regarding an allegation of staff to resident neglect. This report documented concerns about a fall on a specific date.

During an interview this identified resident told Inspector #630 that they remembered having an unwitnessed fall. The resident said they did not ring for staff assistance at that time and had instead told staff the next day about the fall.

The clinical record for this resident included a progress note on a specific date which documented that the resident had reported to staff that they had an unwitnessed fall. The clinical record did not include further documentation that a post fall assessment had been completed or documented by staff.

During an interview an identified staff member told Inspector #630 that if a resident reported that they had an unwitnessed fall on a previous shift the staff were expected to assess the resident and complete a post fall assessment documented in Risk Management and the progress notes in PointClickCare (PCC). The staff member said that this resident had an unwitnessed fall during a specific shift and the resident had reported it to staff the next day. The staff member said that they had not personally done an assessment of the resident regarding that fall.

During an interview the Resident Care Coordinator (RCC) told Inspector #630 that if a resident had an unwitnessed fall the staff were expected to treat it like a normal fall and follow the fall assessment process even if no one saw the resident fall and there should be a progress note, a post fall assessment and a fall risk assessment. The RCC said that the documentation of an assessment of a resident's skin for injury after a fall was built into the post-fall progress note. The RCC said that this resident self-reported a fall on a specific date, and there was no post fall assessment completed or documented for that fall as per the expectations in the home.

Based on interviews with the resident, staff and management as well as a record review, the staff in the home did not conduct a post-fall assessment for a specific unwitnessed fall. (630) [s. 49. (2)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

The licensee has failed to ensure that written policies that were developed for the medication management system to ensure the accurate storage of all drugs used in the home were implemented.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) related to a missing/unaccounted controlled substance.

A review of this CIS report by Inspector #522 noted during the 2300 hours narcotic count on a specific date two identified staff completed the count and were unable to account for a specific medication for an identified resident.

The home's policy titled "Medical Pharmacies - Shift Change Monitored Drug Count" policy 6-6 with a revision date of November 2018, stated in part:
- "Monitored medications (recommended for prn, liquid, patch or injectable) must be counted daily on an ongoing basis at designated shift changes in the home at all times and to deter the opportunity for drug diversion."
- "The shift count must be reconciled with the actual amount of drug in the packaging (not just the last blister number of doses). If an individual count is used, the shift count should be reconciled with this as well to account for actual daily use."
- "Two staff (leaving and arriving), together: a. Count the actual quantity of medications remaining; b. Record the date, time, quantity of medication and sign in the appropriate spaces on the 'Shift Change Monitored Medication Count' form; c. Confirm actual quantity is the same as the amount recorded on the 'Individual Monitored Medication Record' for prn, liquid, patches, or injectable."

At a specific time during the inspection, Inspector #522 observed the monitored drug

count for shift change. One identified staff member completed the count and another recorded the count on the 'Shift Change Monitored Drug Count' form. During the observation it was noted when one staff called out a specific resident's medication they stated one dose and Inspector #522 observed that there were three capsules inside the blister pack. When the staff member counted another identified resident's medication, the staff stated one dose and Inspector #522 observed that there were two pills inside the blister pack. Inspector #522 reviewed the written count on the 'Shift Change Monitored Drug Count' form with the staff and it was noted that the balance remaining for each of the residents was one on the count sheet. The staff stated that they did not count the number of pills in each card when completing the drug count for the monitored medications, rather they counted the number of blister packages remaining. The staff said the practice was for the oncoming registered staff to count the pills and the outgoing registered staff to record the count. Inspector #522 asked how they counted when there was more than one pill in the resident's blister pack and the staff said that they would be counted as one dose. Inspector #522 then asked to review the binder with the shift change monitored medication counts. Inspector #533 reviewed that the counts for these residents and noted that they were documented as one dose instead of the correct number of pills in the blister pack.

On a specific date Inspector #522 observed the individual 'Monitored Medication Record 7-Day Card' forms and the resident's narcotic card for B Wing residents with an identified staff member. It was noted for three identified residents that the count was based on the number of doses not the actual number of pills. The staff member stated the home's process was to count the number of doses or blister packs left on the resident's 7-day card not the actual number of pills remaining.

During an interview the Resident Care Coordinator (RCC) reviewed the Medical Pharmacies "Shift Change Monitored Drug Count" policy with Inspector #522. The RCC stated based on the policy registered staff should be counting each pill during the monitored medication count and not just the number of blister packages remaining. The RCC acknowledged that registered staff were not currently following the policy.

In a telephone interview, the Clinical Consultant Pharmacist (CCP) told Inspector #522 they were not aware that the Medical Pharmacies "Shift Change Monitored Drug Count" policy indicated that registered staff were to count each individual pill not the blister packages. The CCP stated that this may have been part of the revision in November 2018, and the home was not following the current policy.

The licensee has failed to ensure that Medical Pharmacies "Shift Change Monitored Drug Count" policy with a revision date of November 2018, was implemented. (522) [s. 114. (3) (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 the written policies and protocols for the medication management system are implemented, to be implemented voluntarily.

WN #7: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analysed; corrective action was taken as necessary; and a written record was kept of everything required.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) related to a missing/unaccounted controlled substance.

During an interview with an identified staff member they stated they had been working at the time of the incident and had completed the 2300 hours narcotic count with another identified staff member. The staff member stated they had searched the narcotic drawer and were unable to find the missing medication. The staff member stated they had

documented their account of what had occurred and submitted it to the Director of Care but they had not had any follow up with management to discuss the medication incident. The staff member stated they had not initiated a medication incident report.

During an interview the Resident Care Coordinator (RCC) stated that a medication incident report had not been submitted related to the missing medication. The RCC stated they had attended the safety meeting after the date of the CIS report. The RCC reviewed the safety meeting minutes with Inspector #522 and confirmed that the medication incident related to the missing medication was not discussed at the meeting with registered staff as indicated in the CIS report.

During an interview the Resident Assessment Instrument Coordinator (RAI-C) stated they had been asked by the Director of Care (DOC) to look for the missing medication in the narcotic drawer, but they were unable to find it. The RAI-C stated they had attended the PAC Meeting on a specific date, and recalled that the missing medication had been brought up but the Clinical Consultant Pharmacist (CCP) stated they did not have a report related to the missing medication and it therefore it was not discussed.

In a telephone interview, the CCP stated they had not received a medication incident report related to the missing medication. The CCP stated medication incidents were reviewed and analyzed at the PAC meetings but they did not recall if the missing medication was discussed at the PAC meeting.

A review of the PAC meeting minutes and Medical Pharmacies Annual PAC report from the meeting noted under incidents for January/February 2019, no reference to a missing or unaccounted controlled substance.

In an interview, the Executive Director (ED) stated they did not have any documentation related to the medication incident other than the written statement from two staff. The ED stated a medication incident report should have been completed for the missing medication. The ED stated the investigation was done well but there should have been more documentation related to the medication incident.

The licensee has failed to ensure that the medication incident related to a missing controlled substance was (a) documented, reviewed and analyzed; (b) corrective action was taken as necessary; and a written record was kept of everything required under clauses (a) and (b). (522) [s. 135. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that in addition to the requirement under clause (1) (a), all medication incidents and adverse drug reactions are documented, reviewed and analyzed; corrective action is taken as necessary; and a written record is kept of everything required under clauses (a) and (b), to be implemented voluntarily.

Issued on this 9th day of May, 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) :	AMIE GIBBS-WARD (630), JULIE LAMPMAN (522)
Inspection No. / No de l'inspection :	2019_722630_0010
Log No. / No de registre :	027851-18, 030268-18, 031190-18, 003057-19, 006769-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 8, 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 on Bonnie Place 15 Bonnie Place, St Thomas, ON, N5R-5T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Suzanne Mezenberg

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:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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 : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s 20 (1) of the LTCHA.

Specifically the licensee shall ensure the following:
a) Ensure the home's written policy titled "Abuse and Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" is reviewed and revised to ensure it provides clear direction on how the staff and management in the home are to respond to allegations of visitor to resident abuse. This includes, but is not limited to, a review of the directions for immediately reporting alleged abuse to the management in the home, procedures for immediately investigating the alleged abuse, interventions to assist and support residents who have been abused by visitors and the consequences set-out in the policy for visitors who have abused residents. The home must keep a documented record of this review and the revisions made to the policy.

b) All staff and management comply with the home's written policy titled "Abuse and Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" to ensure any instance of family to resident abuse is responded to in accordance with the policy. This includes, but is not limited to, immediately reporting alleged abuse to the management in the home, immediately reporting the allegations to the Ministry of Health and Long-Term Care (MOHLTC), immediately investigating the alleged abuse and providing support to the affected resident.

c) The home's Administrator/Director of Care (DOC) will ensure education is provided to all staff working in the home regarding visitor to resident abuse and the sections of the home's revised written policy titled "Abuse and Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" related to this type of abuse. The home must maintain a documented record of this training which includes the details of the education provided, the date of the education and the signatures of the participants.

Grounds / Motifs :

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

The definition of emotional abuse in Section 2(1) of the Ontario Regulation 79/10

includes "action or behaviour performed by anybody except by a resident including any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization."

The definition of verbal abuse in Section 2(1) of the Ontario Regulation 79/10 includes "any form of verbal communication of a belittling or degrading nature which may diminish the resident's sense of well-being, dignity or self worth made by anyone other than a resident."

The staff in the home failed to comply with the written policy titled "Abuse and Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" with effective date August 2018. This policy stated "abuse, in any form, is a direct violation of the intrinsic right and will not be tolerated." This policy also stated "residents, families and staff must report all situations of suspected or actual abuse to the Executive Director and/or Director of Care, this includes suspicion of abuse of a resident while out on a leave of absence."

This policy included a section titled "Reporting" which stated the following:
- "1. All cases of suspected or actual abuse must be immediately reported to the DOC/Executive Director."
- "2. After receiving notice of the abuse, the DOC/Manager on call will immediately notify the Executive Director of the initiation of an investigation."

This policy also included a section titled "Investigating and Responding to Alleges, Suspected or Witnessed Abuse or Neglect of Resident" with a subsection "Family to Resident Abuse" which stated the following:
- "1. Any staff witnessing an allegation/actual act of abuse (or has reason to believe that an act of abuse occurred while the resident was on a leave of absence) must report it as outlined to their immediate supervisor."
- "2. The supervisor will ensure that the immediate needs of the resident are attended to."
- "4. The DOC/Executive Director will meet with the family to discuss the alleged/actual abuse. The family member should be advised of his/her right to have representation of their choice present during the interview with the DOC/Executive Director and/or police, if applicable."

- "7. A Ministry of Health Critical Incident Summary must be completed."

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-term Care (MOHLTC) related to an incident involving an identified resident and an identified visitor.

During an interview the Executive Director (ED) told Inspector #630 that they were familiar with this CIS report and this resident. The ED said the home had investigated the incident in a specific way and at the time they had not identified this incident as an allegation of abuse.

During interviews with identified staff members they reported they were familiar with this identified resident. The staff expressed that they were aware of concerns related to the way an identified visitor treated the resident on multiple occasions while in the home.

During an interview the Resident Care Coordinator (RCC) told Inspector #630 that the home's program on prevention of abuse and neglect covered visitor to resident abuse but this part of the policy was not as broad as resident to resident or staff to resident abuse. The RCC said they were familiar with this resident and that they had been the manager on-call who submitted the CIS report to the MOHLTC. RCC said they had taken specific actions to investigate the incident. The RCC said that at the time it did not occur to them that this was an incident of visitor to resident abuse, but in retrospect it seemed like it could fit into that category. The RCC said they were not personally involved in any follow-up about this incident. The RCC reviewed the progress notes for this resident and acknowledged there was a documented allegation of visitor to resident abuse on another specific date. When asked if staff identified concerns with how the visitor was treating this resident, the RCC said "always".

The clinical record for this identified resident included documentation on the date of the CIS report which indicated the resident's condition included being "upset." The clinical record also included progress notes documented by various staff regarding concerns with the way this specific visitor was treating this resident. The progress notes described specific actions that had been taken by the staff and management in the home.

During a follow-up interview, the Executive Director (ED) told Inspector #630 that the home's policy on prevention of abuse and neglect did cover family or visitor to resident abuse. The ED said that the policy indicated that the consequences for visitors or family members who were found to have abused a resident was that they would talk to the family or the Power of Attorney and included no further direction. When asked if the policy included how to support residents who had been affected by visitor or family to resident abuse, the ED said that it directed that the immediate needs of the resident were to be attended and you would contact the family. When asked if based on a review of this CIS report for this identified resident whether this should have been immediately investigated as an incident of alleged visitor to resident emotional abuse, the ED said that looking back they should have done a CIS report for alleged abuse. The ED acknowledged to Inspector #630 that this incident was not investigated as abuse. When asked if there were any concerns with the way this visitor treated the resident when visiting in the home, the ED described specific concerns and the actions taken in the home. The ED said that they did not think that a specific documented incident was reported to the Director of Care (DOC) or ED as an allegation of abuse at the time and based on the policy staff should have reported this allegation. The ED said this was not investigated as an allegation of abuse and it was not reported to the MOHLTC.

The home has failed to ensure that the written policy to promote zero tolerance of emotional and verbal abuse of residents by visitors was complied with. Based on the CIS report, interviews with staff and management as well as a review of the resident's clinical records, there were multiple reported and observed incidents of alleged abuse by a specific visitor towards this resident. The staff in the home failed to report these incidents immediately to the management in the home, the management in the home did not immediately investigate the allegations of abuse, the management in the home did not take immediate action to protect the resident from further incidents of visitor to resident abuse, the staff or management in the home did not take actions to determine what the "immediate needs" of the resident were after the incidents of visitor to resident abuse to determine what victim supports were needed, the management did not meet with the accused family member to discuss the allegations and the staff and management in the home did not notify the MOHLTC of the allegations of abuse. (630) [s. 20. (1)]

The severity of this issue was determined to be a level 3 as there was actual risk of harm. The scope of the issue was a level 2 as it was a pattern. The home had a level 2 history as they had one or more findings of non-compliance, none of which were for the same subsection. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 130. 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.

Order / Ordre :

2) The licensee must be compliant with r. 130. (3) of Ontario Regulation 79/10.

Specifically, the licensee must ensure that:

a) Monthly audits are completed 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.

b) Monthly audits are documented, including when it was completed and who completed the audit.

c) All documentation is kept in the home related to the monthly audits and any action taken related to discrepancies.

Grounds / Motifs :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including a monthly audit undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) related to a missing/unaccounted controlled substance.
A review of the CIS report by Inspector #522 noted during the narcotic count on a specific date and time two staff members completed the narcotic count and were unable to account for a specific medication for an identified resident.

A review of the 'Shift Change Monitored Medication Count' for C Wing for specific time periods, noted the count showed this identified resident had a specific number of the medication remaining and in one instance one number was written in bold over another number. Inspector #522 was unable to determine when the change was made and who made the change as there were no initials beside the change.

During an interview an identified staff member said they had documented the count for this area on this specific date. The staff said normally when an error was made they would cross out the error and initial the change and have the other staff member who completed the count initial the change also. The staff member could not recall why they did not do this when they changed the count for this identified resident.

Further review of the 'Shift Change Monitored Medication Count' for another specific time period noted 10 entries where the numbers had been changed on the 'Shift Change Monitored Medication Count' sheet, seven of the entries were illegible. Inspector #522 was unable to determine when the changes were made and who made the changes as there were no initials beside the numbers that had been changed.

During an interview with another staff member they stated they had documented the count on a specific date. When asked about four entries that had been changed on the count, three of which were illegible, the staff member stated they could not recall why the numbers on the count were changed. The staff member stated normally when they made an error in the count they would cross the error out with a line and initial the change.

During another interview with another identified staff member they described the

process for completing the count on a specific date. When asked about four of the entries that had been changed on the count the staff member reviewed the count sheet and acknowledged the numbers on the count were difficult to read. The staff member stated they really could not remember what exactly happened and when they made a correction on the count they usually initialled it. When asked about the changes made to an identified resident's count on a specific date, the staff member stated they thought they might have followed what was above on the count and then realized the counts were accidentally in the wrong box and fixed it. The staff member acknowledged they did not initial that they had made changes to the counts.

A review of the 'Shift Change Monitored Medication Count' sheets for a specific date with two other identified staff noted that the entire box had been scratched out for the count on a specific date for a specific medication. The entry below had a 'one' and then another number that had been scratched out which was illegible. The staff stated that those were their errors, and that they wrote the wrong number in the box and it should have been in the next box. The staff stated they had initialled above the 1500 hours count.

In an interview, the Resident Care Coordinator (RCC) reviewed the 'Shift Change Monitored Medication Count' for specific dates. The RCC acknowledged that there were counts that were illegible as numbers had been changed and written over top of each other. The RCC stated the 'Shift Change Monitored Medication Count' sheets were reviewed and audited monthly. The RCC stated the audits were completed by the Director of Care (DOC).

Review of Medical Pharmacies "Shift Change Monitored Drug Count" policy 6-6 with a revision date of November 2018, noted a 'Narcotic/Controlled Drugs Monthly Audit' form which stated the following: "This form is used to audit the daily count sheets of narcotic/controlled drugs monthly. After completion, unmet (s) are to be addressed with action plans. Store completed audits in Director's office for 3 years." The form in part, included audits that the physical quantity of drug matched the count on the individual count and shift count sheets, that shift count was completed by two nurses, shift count sheets were not pre-signed and no corrections or changes were made to previous counts. The policy also stated that monthly audits were to be tracked using the 'Narcotic/Controlled Drugs Audit Annual Tracking' form.

During an interview the Caressant Care Regional Director Long-Term Care (RDLTC) told Inspector #522 if registered staff had made a change to the Monitored Drug Count sheet they would be expected to initial the change and correct the error to ensure the count was correct. The RDLTC stated the monthly audits of the 'Shift Change Monitored Medication Count' sheets would be completed by the DOC and would be in the DOC's office.

During another interview the RCC and Director of Care (DOC) stated they were unable to find any completed 'Narcotic/Controlled Drugs Monthly Audit' forms for January to March 2019. The DOC provided Inspector #522 the 'Narcotic/Controlled Drugs Audit Annual Tracking' form which noted an audit was completed on March 25, 2019 for January and February 2019.

Review of the 'Narcotic/Controlled Drugs Audit Annual Tracking' form for February 2019 for C Wing noted there were six missing signatures on the count sheets and discrepancies were identified. The 'Narcotic/Controlled Drugs Audit Annual Tracking' form for February 2019 for B Wing noted there were two missing signatures and discrepancies were identified.

In a follow-up interview the RDLTC said they had been the interim DOC from the later part of January, February and March 2019. The RDLTC stated they had completed the 'Narcotic/Controlled Drugs Audit Annual Tracking' form on March 25, 2019, for January and February 2019. The RDLTC stated when they had noted there were discrepancies that was to indicate there were missing signatures on the 'Shift Change Monitored Drug Count' sheets. The RDLTC stated they had completed the 'Narcotic/Controlled Drugs Monthly Audit' forms but acknowledged that there was no documented evidence to support that the monthly audits were completed.

The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including a monthly audit undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered. (522) [s. 130. 3.]

The severity of this issue was determined to be a level 1 as there was no risk of

harm. The scope of the issue was a level 3 as it was widespread. The home had a level 2 history as they had one or more area of non-compliance, none of which were for the same subsection. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 229. (5)

Specifically the licensee must:
a) Review and revise the home's Infection Prevention and Control program policies related to outbreak management to ensure they provide clear direction to staff on the procedure for monitoring and recording symptoms indicating the presence of infection on each shift. The home must keep a documented record of this review and the revisions made to the policy.

b) Ensure that all leadership team members, Registered Nurses (RNs) and Registered Practical Nurses (RPNs) working in the home are re-educated on the Infection Prevention and Control program policies and strategies related to outbreak management. The home must keep a documented record of the education provided.

c) Implement the revised Infection Prevention and Control program policies related to outbreak management to ensure that on every shift the symptoms indicating the presence of infection are recorded and immediate action is taken as required.

d) Ensure an auditing process is developed and fully implemented to ensure the symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices, the symptoms are recorded and that immediate action is taken as required. This auditing process must be documented including the auditing schedule, the names of the people conducting the audit, the residents who have been audited, the results of the audit and what actions were taken in regards to the audit results.

Grounds / Motifs :

1. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices and that the symptoms were recorded and immediate action was taken as required.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-term Care (MOHLTC) regarding an allegation of staff to

resident neglect that the management of the home received. This CIS report stated an identified resident's family had reported specific concerns about the care provided to this resident.

During an interview this identified resident told Inspector #630 that they had experienced a change in their health which involved a specific symptom during a specific time period.

The clinical record for this resident included documentation in the electronic Medication Administration Record (eMAR) for specific dates showing the resident had been given an as needed (PRN) dose of specific medications for a specific symptom. The only date vital signs, including temperature and oxygen saturation levels, were recorded in the "weight and vitals" section of PointClickCare (PCC) for this resident was on one specific date during a specific time period. There were no documented progress notes regarding signs or symptoms of infection, apart from the notes regarding the administration of as needed medication and the concern raised by the family, for a specific time period. There was a progress note by the nurse for a specific date which documented that the resident could have a specific type of infection and specific interventions were ordered. The home's outbreak line listing showed that this resident was added on a specific date with one symptom noted and no other symptoms documented. The line listing for this resident had no documentation for "temperature;" "prophylaxis/vaccination/treatment;" "complications" or "resolved date."

During an interview with an identified staff member they told Inspector #630 that the home had an infection prevention and control (IPAC) program in place and they recently had a specific type of outbreak in the home. The staff member said they would know which residents were considered to be symptomatic of an infection through the outbreak line listing. The staff member said they would document symptoms and vital signs in a progress note and at times, if a resident was in isolation, then it would be set up in the eMAR to automatically document vital signs. When asked what the process in the home was for monitoring residents for signs of infection, the staff member said they would monitor when doing vitals and ask the resident how they were feeling and that it would be documented in a progress note. The staff member said that they used the line listing to document at the onset of an infection but any new symptoms or the

monitoring of symptoms would be documented in a progress note. The staff member said that they were familiar with this resident and this resident had requested as needed medication from them during a specific time period and the family had expressed concerns to them about a specific symptom.

The Executive Director (ED) provided Inspector #630 with a copy of the home's investigation documentation related to this CIS report and this documentation was reviewed as part of the inspection. There was no documented evidence in the investigation package to show that the symptoms of respiratory infection had been monitored or documented by staff on each shift.

During an interview the Resident Care Coordinator (RCC) said they were the lead for the infection prevention and control (IPAC) program in home. The RCC said they recently had a specific type of outbreak in the home and Public Health was unable to determine the causative agent for the outbreak. The RCC said that staff would know which residents were considered to be symptomatic of the infection through the line listing as well as discussions at report. When asked what the process in the home was for monitoring residents for signs of respiratory infection, the RCC said that the registered staff would monitor when handing out the medication and the Personal Support Workers (PSWs) would monitor when doing care and then would report to the registered nursing staff. When asked what the process in the home was for documenting signs of respiratory infection, the RCC said they would expect to see a progress note each shift and it would be expected that this would include the monitoring of vital signs. When asked how they would know if a specific symptom had been monitored by staff during an outbreak, the RCC said that they would expect to see some sort of documentation or charting and if they did not see the documentation then there would be no way to know. The RCC said that the home had policies regarding outbreak management as part of the IPAC program, but these policies did not provide direction for staff related to the monitoring and documentation of symptoms. The RCC said they were familiar with this resident and based on the documentation in PCC the family brought forward concerns to staff about a specific symptom on a specific date. The RCC said that the next documentation regarding assessment of this symptom was a note by the nurse practioner seven days later. When asked if this resident was considered to be one of the cases for the outbreak, the RCC said that they were and the resident had been added to the line listing on a specific date. When

asked if this resident had been having symptoms of this infection prior to that date, the RCC said that nothing had been reported to them.

The home's policy titled "Outbreak Control for Communicable Disease – Departmental Response During An Outbreak" with revised date April 2018, included that the "Nursing Staff (registered): investigates reported signs and symptoms; records pertinent information on the surveillance form." This policy did not provide any further direction regarding the monitoring or recording of symptoms of infection.

The home's policy titled "Outbreak Management" with revised date April 2018, included: "1. Review recent line list-initiate a separate line listing for ill resident and for staff." "2. Review symptoms to date-confirm if they are related to respiratory, enteric or influenza outbreak." "5. Notify Public Health to receive further direction." This policy did not provide any further direction regarding the monitoring or recording of symptoms of infection.

The "Outbreak Control Measures Checklist" for Respiratory Outbreak with "Outbreak Status/Date Confirmed March 14, 2019" stated that the facility was to "monitor for new cases" and "track suspected and confirmed cases on an outbreak line listing." This checklist did not provide any further direction regarding the process for monitoring or recording of symptoms of infection.

During an interview the Executive Director (ED) told Inspector #630 that they were familiar with this resident and had been involved in investigating the allegations of neglect reported in the CIS report. The ED said that in response to the concern they had met with the staff, reviewed the eMAR for use of as needed medication and reviewed documentation. The ED said they were not sure when the resident's symptom had been added to the doctor's list for assessment. When asked if the home was in outbreak at the time of this concern, the ED said they could not recall. The ED said that this resident had been diagnosed with a specific condition and started on a specific type of medication.

B) During an interview with another staff member they told Inspector #630 that the home did have an IPAC program in place and the home recently had a specific type of outbreak which affected all areas of the home. The staff member

said they would know which residents were considered to be symptomatic through verbal report, reading through the written shift report, from the line listing as well as based on reports from the PSW staff. When asked what staff were expected to do if a resident had a new symptom, the staff member said that if it was just one symptom they would monitor for 24 hours then if there was another symptom they would isolate them and add them to the line list. When asked what type of monitoring would be done, the staff member said it would include a chest assessment, full set of vitals including oxygen saturation and temperature and sometimes respiratory rates. When asked what the expectation was in the home regarding documentation of symptoms during an outbreak, the staff member said in the progress notes there should be a follow-up note and the vitals recorded in the vitals section of PCC. The staff member said they were familiar with an identified resident and this resident had two infections in a row in a specific time period. When asked what symptoms of infection this resident had shown, the staff member described four symptoms. The staff member said this resident had a specific type of test and had been diagnosed with a specific type of infection.

The clinical record for this resident included the documentation in the electronic Medication Administration Record (eMAR) for specific dates showing the resident had been given an as needed (PRN) dose of specific medications for a specific symptoms. The only date the resident's temperature was recorded in the "weight and vitals" section of PointClickCare (PCC) was on one specific date during a specific time period. The progress notes for a specific time period, included no documentation regarding the monitoring, assessing or recording of the resident's symptoms of infection for 25 out of 33 (76 per cent) of shifts. The progress notes for another specific time period, included no documentation regarding the monitoring, assessing or recording of the resident's symptoms of infection for 33 out of 36 (92 per cent) of shifts. The home's outbreak line listing showed that this resident was added on a specific date with three symptoms noted.

During an interview the RCC told Inspector #630 that they were familiar with this resident and this resident had been considered to be part of the home's recent outbreak. When asked when this resident was added to the outbreak line listing, the RCC said that it seemed confusing as this resident was not added until a specific date and they were not sure why the resident had not been added

earlier. The RCC said it was the expectation in the home that staff would monitor for signs of respiratory infection on every shift and that the symptoms would be recorded in the progress notes.

C) During an interview with an identified staff member they said they were familiar with another identified resident and this resident had experience a change in their health. The staff member reviewed the progress notes for this resident and said that they had a specific type of infection and the home was in an outbreak at the time. The staff member said that the notes showed that the resident had specific symptoms and was started on a specific type of medication.

The clinical record for this resident included the documentation in the electronic Medication Administration Record (eMAR) for specific dates showing the resident had been given an as needed (PRN) dose of specific medications for specific symptoms. There were no progress notes documented for a specific time period. The home's outbreak line listing showed that this resident was added on a specific date with three symptoms noted.

During an interview the RCC told Inspector #630 that they were familiar with this resident and this resident had been considered to be part of the home's recent outbreak. The RCC said the resident had been added to the line listing on a specific date with specific symptoms. The RCC reviewed the progress notes for this resident and said there was not any documentation of monitoring of the symptoms for a specific time period and it was the expectation that would have been done. The RCC acknowledged there was a delay in the initiation of the treatment as the specific medication was not contained in the home's emergency drug box and that the pharmacy indicated that they only did special deliveries of medications in emergency situations.

Based on interviews, record reviews and policy reviews, the licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in three identified resident were monitored in accordance with evidence-based practices, the symptoms were recorded and immediate actions were taken as required. (630) [s. 229. (5)]

The severity of this issue was determined to be a level 3 as there was actual risk

of harm. The scope of the issue was a level 3 as it was widespread. The home had a level 3 history as they had one or more findings of non-compliance related to this subsection of the legislation that included:

- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued May 4, 2018 (2018_606563_0005). (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 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 8th day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amie Gibbs-Ward

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