Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 24, 2019	2019_263524_0027 (A1)	009518-19, 009547-19, 009548-19, 009549-19, 011603-19, 013655-19, 013914-19	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

Amended by INA REYNOLDS (524) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee requested an extension on the compliance due date for CO #001 related to s. 8 policy related to head injury routine. The CDD of September 30, 2019 will be amended with extension of 1 week with date of October 8, 2019

Issued on this 24th day of September, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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Licensee/Titulaire de permis

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264 Norwich Avenue WOODSTOCK ON N4S 3V9

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15 Bonnie Place St Thomas ON N5R 5T8

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

Amended by INA REYNOLDS (524) - (A1)

Amended 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): August 1, 2, 6, 7 and 8,

The following Critical Incidents were completed within the inspection:

Log #013655-19 / CIS #2730-000019-19 related to responsive behaviours

Log #013914-19 / CIS #2730-000020-19 related to falls management and reporting to the Director.

The following Follow-up intakes were completed within the inspection:

Log #009518-19 for compliance order #001 from Follow-up inspection #2019_722630_0009 related to the Head Injury Routine policy

Log #009547-19 for compliance order #001 from Follow-up inspection #2019_722630_0010 related to the abuse policy

Log #009548-19 for compliance order #002 from Follow-up inspection #2019_722630_0010 related to medication

Log #009549-19 for compliance order #003 from Follow-up inspection #2019_722630_0010 related to infection prevention and control

Log #011603-19 for compliance order #001 from Follow-up inspection #2019_674610_0007 related to safe and secure environment.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Director of Clinical Services and Education, the Resident Care Coordinator, the Nutrition Manager, a physiotherapist, Registered Nurses, the Behavioural Supports Ontario (BSO) Registered Practical Nurse, Registered Practical Nurses, a Ward Clerk, Personal Support Workers, a housekeeping aide and residents.

The inspector(s) also observed residents and the care provided to them, resident and staff interactions, observed resident rooms, common areas and smoking areas, reviewed health care records including assessments and care planning interventions for identified residents, and reviewed policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Responsive Behaviours
Safe and Secure Home

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

- **3 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #001	2019_722630_0010	522
O.Reg 79/10 s. 229. (5)	CO #003	2019_722630_0010	524
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2019_674610_0007	524

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On May 8, 2019, during a Follow up inspection #2019_722630_0009 compliance order #001 was issued and ordered the licensee to take action to achieve compliance by ensuring:
“a) The home's policy titled "Head Injury Routine" is reviewed and revised to ensure it provides clear direction for staff. This is to include, but is not limited to, a review of the directions for completing the Glasgow Coma Scale (GCS) when a resident is sleeping at the time of the assessment. The home must keep a documented record of the review.
b) The home's Administrator/Director of Care (DOC) ensures education is provided to all Registered Nurses (RNs) and Registered Practical Nurses (RPNs) working in the home, regarding the home's revised "Head Injury Routine" policy.
c) The leadership in the home continues to audit the staff's compliance with the "Head Injury Routine" policy. The auditing process must be documented including the names of the people conducting the audits, the residents who have been audited, the results of the audits and what was done with the results of the audits.
d) The home's “Head Injury Routine” policy is fully complied with.”
The compliance due date was June 30, 2019.

Ontario Regulation 79/10 s. 48 (1) 1 states, “Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and

implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury."

Ontario Regulation 79/10 s. 30 (1) 1 states, "Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required."

The home's policy "Head Injury Routine" with a review date of May 2019, noted in part the following:
"Immediately after a resident sustains a trauma to the head or an unwitnessed fall, the Registered Nurse in charge is to assess the resident, using the Glasgow Coma Scale and do a complete set of vital signs. Using the Glasgow Coma Scale as a documentation tool and vital signs, assess the resident for 72 hours with the following frequency: Every half hour for the first two hours following the injury, every hour for the next four hours, every four hours for the next eight hours, every shift for the remainder of the 72 hour monitoring."

A review of the Head Injury Routine Audits completed for a specific time period, noted resident #006 had an unwitnessed fall on specific date. A review of resident #006's Glasgow Coma Scale (GCS) initiated on a specific date and time, noted the scheduled assessment for an identified date and time, indicated 'none' under Coma Scale and under limb movement 'sleeping' was noted.

A review of the Head Injury Routine Audit on a specific date, for resident #006's GCS noted that there were no incomplete sections on the GCS.

In an interview, on a specific date, Registered Nurse #104 stated if a resident was sleeping when they were to complete the GCS that they would wake the resident up. RN #104 stated if the resident refused to have the GCS completed, then they would make a note in the progress notes which stated that the resident refused to have the head injury routine completed.

In an interview, on a specific date, Resident Care Coordinator (RCC) #103 stated they had completed the Head Injury Routine Audit for resident #006. The

inspector reviewed the Head Injury Routine Audit for the specific date, for resident #006's GCS with RCC #103. RCC #103 acknowledged that they had indicated that the GCS for resident #006 was complete and there were no areas of concern.

RCC #103 reviewed resident #006's GCS on the specific date, with the inspector. RCC #103 acknowledged that staff had indicated 'none' under coma scale and 'sleeping' under limb movement. RCC #103 stated they were not sure why the registered staff member would put sleeping and just complete the vitals. RCC #103 stated there was still work that the home needed to do.

A review of education provided to registered staff on the Head Injury Routine policy noted 21 out of 22 registered staff had completed the revised Head Injury Routine policy review. The inspector reviewed the education with RCC #103. RCC #103 acknowledged that one of the Registered Practical Nurses (RPN) had not completed the review of the home's revised "Head Injury Routine" policy. RCC #103 was unable to explain why the RPN had not yet completed the review.

In a telephone interview, on a specific date, Director of Clinical Services and Education (DCSE) #111 stated the home's "Head Injury Policy" had been reviewed and revised. DCSE #111 stated the policy did not specifically state staff were to wake a resident if the resident was sleeping to complete the GCS, rather the frequency of the GCS was included in the policy and it stated to assess the resident for 72 hours and included the frequency. DCSE #111 stated therefore if it stated the resident was to be assessed at a certain time that meant if the resident was sleeping at that time staff were to wake the resident to complete the assessment. DCSE #111 stated the frequency was also added to the GCS sheet. DCSE #111 stated that the Caressant Care Regional Director Long-Term Care had spoken to the registered staff regarding the guidelines of what to do if a resident was sleeping when they completed the GCS.

In an interview, on a specific date, Director of Care (DOC) #100 reviewed resident #006's GCS and stated that sleeping was an unacceptable entry on the GCS. DOC #100 stated the home had reviewed with registered staff that sleeping was not an appropriate entry when completing the GCS.

DOC #100 reviewed the home's "Head Injury Routine" policy with a review date of May 2019, with the inspector. DOC #100 stated the policy states, "Facility Head Injury routine is to be followed as per Policy and Procedure unless otherwise

stated by the Attending Physician. A change in the level of responsiveness is the most sensitive indicator of improvement or deterioration. If there is a decreased level of responsiveness, the physician and Power of Attorney are to be notified." DOC #100 stated that management took that statement as you need to wake the resident to assess their level of consciousness. DOC #100 stated if the policy needed to be clearer than it was, then the home would need to do that.

The licensee has failed to ensure that the home's "Head Injury Routine" policy was complied with.

The severity of this issue was determined to be a level 2 as there was minimal risk. The scope of the issue was a level 1 as it was isolated. The home had a level 4 history as they had one or more non-compliances related to this subsection of the legislation that included two compliance orders:
- Written Notification (WN) and Compliance Order (CO) issued May 8, 2019 (2019_722630_0009) with a compliance due date of June 30, 2019
- Written Notification (WN) and Compliance Order (CO) issued February 15, 2019 (2018_725522_0017) with a compliance due date of March 29, 2019
- WN and Voluntary Plan of Correction (VPC) issued May 4, 2018 (2018_606563_0005). [s. 8. (1) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

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

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

Findings/Faits saillants :

1. The 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.

On May 8, 2019, during a Critical Incident System inspection #2019_722630_0010 compliance order #002 was issued and ordered the licensee to take action to achieve compliance by ensuring that monthly audits were completed 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 compliance due date was July 31, 2019.

In an interview, on August 7, 2018, Director of Care (DOC) #100 provided inspector with the Narcotic/Controlled Drugs Monthly Audit for C Unit for July 2019.

When inspector requested the Narcotic/Controlled Drugs Monthly Audit for B Unit, DOC #100 stated that they alternated completing monthly audits of the narcotic storage areas and that an audit of Narcotic/Controlled Drugs had not been completed for B unit for July 2019.

Review of Medical Pharmacies "Shift Change Monitored Drug Count" policy 6-6 stated in part, "A monthly audit of the narcotic and controlled medications is required by the DOC, manager or delegate in all storage areas to ensure all narcotic and controlled drugs are present in the right quantities. The DOC/delegate and a witness will audit monthly the count sheets comparing the count to the quantity of medication remaining."

In an interview, DOC #100 stated that they were unaware that audits of all narcotic and controlled medication storage areas were to be completed monthly. DOC #100 stated that now that they were aware they would complete an audit for all narcotic storage areas in August.

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 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 4 history as they had one or more non-compliance related to this subsection of the legislation that included one compliance order:
-Written Notification (WN) and Compliance Order (CO) issued May 8, 2019 (2019_722630_0010) with a compliance due date June 30, 2019. [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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed within three business days after the occurrence of an incident that caused an injury to resident #004 for which the resident was taken to a hospital and resulted in a significant change in the resident's health condition.

This inspection was initiated as a result of a Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, regarding a fall incident for resident #004. Review of the CIS stated that the resident had a fall on a specific date, and was transferred to hospital and diagnosed with an identified injury.

Review of resident #004's clinical record on PointClickCare (PCC) showed the following:
-the progress notes by a registered nurse on a specific date, documented that the resident's family called the home to advise that resident #004 had an identified injury.
-the progress notes, noted the resident had returned from hospital at a specific time and physio had assessed the resident on return.
-a Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment was completed on a specific date. The Resident Assessment Protocol (RAP) notes documented the significant care changes.

In an interview, on a specific date, Director of Care #100 acknowledged that resident #004 had a significant change in health status and said that the home did not report the incident to the Director within three business days after the occurrence of the injury.

The licensee failed to ensure that the Director was informed within three business days of an incident that caused an injury for which resident #004 was taken to a hospital and resulted in a significant change in the resident's health condition. [s. 107. (3.1) (b)]

2. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident: (i) names of all residents involved in the incident.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date. Review of the CIS report showed that the name of the resident involved in the incident was not mentioned in the report. It was noted that the resident had sustained a fall on a specific date, and was transferred to hospital and diagnosed with a specific injury. In addition, the CIS report showed an amendment was requested by the Director, requesting the "Resident's full name. Clarify history of falls including dates and injuries noted within the last 6 months. Specific strategies and actions planned to prevent recurrence."

A review of resident #004's clinical record including the care plan, progress notes and Resident Assessment Instrument Minimum Data Set (RAI-MDS) showed that resident #004 had returned from hospital and had a significant change in health

status.

The inspector reviewed the Long-Term Care Homes Critical Incident System, used by the home to report incidents to the Director, and found no amended CIS report.

In an interview, Director of Care #100 acknowledged that the resident's name had not appeared in the critical incident report and the amendment to the CIS was not completed as requested by the Director. [s. 107. (4) 2. i.]

Issued on this 24th day of September, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by INA REYNOLDS (524) - (A1)
Inspection No. / No de l'inspection :	2019_263524_0027 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	009518-19, 009547-19, 009548-19, 009549-19, 011603-19, 013655-19, 013914-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 24, 2019(A1)
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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To 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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_722630_0009, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with r. 8. (1) of Ontario Regulation 79/10. Specifically, the licensee must ensure that:
a) The home's Administrator/Director of Care (DOC) ensures education is provided to all Registered Nurses (RNs) and Registered Practical Nurses (RPNs) working in the home, regarding the home's "Head Injury Routine" policy.
b) The leadership in the home continues to audit the staff's compliance with the "Head Injury Routine" policy. The auditing process must be documented including the names of the people conducting the audits, the residents who have been audited, the results of the audits and what was done with the results of the audits.
c) The home's "Head Injury Routine"policy is fully complied with.

Grounds / Motifs :

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

On May 8, 2019, during a Follow up inspection #2019_722630_0009 compliance

order #001 was issued and ordered the licensee to take action to achieve compliance by ensuring:
"a) The home's policy titled "Head Injury Routine" is reviewed and revised to ensure it provides clear direction for staff. This is to include, but is not limited to, a review of the directions for completing the Glasgow Coma Scale (GCS) when a resident is sleeping at the time of the assessment. The home must keep a documented record of the review.
b) The home's Administrator/Director of Care (DOC) ensures education is provided to all Registered Nurses (RNs) and Registered Practical Nurses (RPNs) working in the home, regarding the home's revised "Head Injury
Routine" policy.
c) The leadership in the home continues to audit the staff's compliance with the "Head Injury Routine" policy. The auditing process must be documented including the names of the people conducting the audits, the residents who have been audited, the results of the audits and what was done with the results of the audits.
d) The home's "Head Injury Routine" policy is fully complied with."
The compliance due date was June 30, 2019.

Ontario Regulation 79/10 s. 48 (1) 1 states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury."

Ontario Regulation 79/10 s. 30 (1) 1 states, "Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required."

The home's policy "Head Injury Routine" with a review date of May 2019, noted in part the following:

"Immediately after a resident sustains a trauma to the head or an unwitnessed fall, the Registered Nurse in charge is to assess the resident, using the Glasgow Coma

Scale and do a complete set of vital signs. Using the Glasgow Coma Scale as a documentation tool and vital signs, assess the resident for 72 hours with the following frequency: Every half hour for the first two hours following the injury, every hour for the next four hours, every four hours for the next eight hours, every shift for the remainder of the 72 hour monitoring."

A review of the Head Injury Routine Audits completed for a specific period of time, noted resident #006 had an unwitnessed fall on a specific date. A review of resident #006's Glasgow Coma Scale (GCS) initiated on a specific date and time, noted the scheduled assessment on a specific date and time, indicated 'none' under Coma Scale and under limb movement 'sleeping' was noted.

A review of the Head Injury Routine Audit for a specific date, for resident #006's GCS noted that there were no incomplete sections on the GCS.

In an interview, on a specific date, Registered Nurse #104 stated if a resident was sleeping when they were to complete the GCS that they would wake the resident up. RN #104 stated if the resident refused to have the GCS completed, then they would make a note in the progress notes which stated that the resident refused to have the head injury routine completed.

In an interview, on a specific date, Resident Care Coordinator (RCC) #103 stated they had completed the Head Injury Routine Audit for resident #006. The inspector reviewed the Head Injury Routine Audit dated for a specific date, for resident #006's GCS with RCC #103. RCC #103 acknowledged that they had indicated that the GCS for resident #006 was complete and there were no areas of concern.

RCC #103 reviewed resident #006's GCS for the specific date, with the inspector. RCC #103 acknowledged that staff had indicated 'none' under coma scale and 'sleeping' under limb movement. RCC #103 stated they were not sure why the registered staff member would put sleeping and just complete the vitals. RCC #103 stated there was still work that the home needed to do.

A review of education provided to registered staff on the Head Injury Routine policy noted 21 out of 22 registered staff had completed the revised Head Injury Routine policy review. The inspector reviewed the education with RCC #103. RCC #103 acknowledged that one of the Registered Practical Nurses (RPN) had not completed

the review of the home's revised "Head Injury Routine" policy. RCC #103 was unable to explain why the RPN had not yet completed the review.

In a telephone interview, on a specific date, Director of Clinical Services and Education (DCSE) #111 stated the home's "Head Injury Policy" had been reviewed and revised. DCSE #111 stated the policy did not specifically state staff were to wake a resident if the resident was sleeping to complete the GCS, rather the frequency of the GCS was included in the policy and it stated to assess the resident for 72 hours and included the frequency. DCSE #111 stated therefore if it stated the resident was to be assessed at a certain time that meant if the resident was sleeping at that time staff were to wake the resident to complete the assessment. DCSE #111 stated the frequency was also added to the GCS sheet. DCSE #111 stated that the Caressant Care Regional Director Long-Term Care had spoken to the registered staff regarding the guidelines of what to do if a resident was sleeping when they completed the GCS.

In an interview, on a specific date, Director of Care (DOC) #100 reviewed resident #006's GCS and stated that sleeping was an unacceptable entry on the GCS. DOC #100 stated the home had reviewed with registered staff that sleeping was not an appropriate entry when completing the GCS.

DOC #100 reviewed the home's "Head Injury Routine" policy with a review date of May 2019, with the inspector. DOC #100 stated the policy states, "Facility Head Injury routine is to be followed as per Policy and Procedure unless otherwise stated by the Attending Physician. A change in the level of responsiveness is the most sensitive indicator of improvement or deterioration. If there is a decreased level of responsiveness, the physician and Power of Attorney are to be notified." DOC #100 stated that management took that statement as you need to wake the resident to assess their level of consciousness. DOC #100 stated if the policy needed to be clearer than it was, then the home would need to do that.

The licensee has failed to ensure that the home's "Head Injury Routine" policy was complied with.

The severity of this issue was determined to be a level 2 as there was minimal risk. The scope of the issue was a level 1 as it was isolated. The home had a level 4 history as they had one or more non-compliances related to this subsection of the

legislation that included two compliance orders:

-Written Notification (WN) and Compliance Order (CO) issued May 8, 2019 (2019_722630_0009) with a compliance due date of June 30, 2019.
- Written Notification (WN) and Compliance Order (CO) issued February 15, 2019 (2018_725522_0017) with a compliance due date of March 29, 2019;
- WN and Voluntary Plan of Correction (VPC) issued May 4, 2018 (2018_606563_0005). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 08, 2019(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2019_722630_0010, CO #002;

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 :

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.

On May 8, 2019, during a Critical Incident System inspection #2019_722630_0010 compliance order #002 was issued and ordered the licensee to take action to achieve compliance by ensuring that monthly audits were completed 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 compliance due date was July 31, 2019.

In an interview, on August 7, 2018, Director of Care (DOC) #100 provided inspector with the Narcotic/Controlled Drugs Monthly Audit for C Unit for July 2019.

When inspector requested the Narcotic/Controlled Drugs Monthly Audit for B Unit, DOC #100 stated that they alternated completing monthly audits of the narcotic storage areas and that an audit of Narcotic/Controlled Drugs had not been completed for B unit for July 2019.

Review of Medical Pharmacies "Shift Change Monitored Drug Count" policy 6-6 stated in part, "A monthly audit of the narcotic and controlled medications is required by the DOC, manager or delegate in all storage areas to ensure all narcotic and controlled drugs are present in the right quantities. The DOC/delegate and a witness will audit monthly the count sheets comparing the count to the quantity of medication remaining."

In an interview, DOC #100 stated that they were unaware that audits of all narcotic and controlled medication storage areas were to be completed monthly. DOC #100 stated that now that they were aware they would complete an audit for all narcotic storage areas in August.

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 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 4 history as they had one or more non-compliances related to this subsection of

the legislation that included one compliance order:
-Written Notification (WN) and Compliance Order (CO) issued May 8, 2019 (2019_722630_0010) with a compliance due date June 30, 2019.

(522)

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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

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

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

Issued on this 24th day of September, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by INA REYNOLDS (524) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

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