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 sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 24, 2017	2016_229213_0039	004840-16, 008948-16, 015639-16, 017131-16, 021944-16, 027293-16, 027733-16, 033028-16, 033029-16, 035063-16, 000464-17, 000590-17, 000857-17, 001129-17, 001413-17, 001869-17	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 WOODSTOCK NURSING HOME
81 FYFE AVENUE WOODSTOCK ON N4S 8Y2

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

RHONDA KUKOLY (213), MARIAN MACDONALD (137), MELANIE NORTHEY (563), SHERRI COOK (633)

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): October 28, 31, November

1-4, 8-10, 14-18, 29, 30, December 1, 2, 5-8, 12-16, 19, 2016, January 3-6, 9-13, 16-20, 24, 26, 31, February 1-3, 6-10,13-17, 21-24, 28, March 1-3, 6, 7, 2017

The following critical incidents are included in this inspection:
Log #004840-16, critical incident #2636-000006-16 related to an injury a resident sustained during a transfer.
Log #008948-16, critical incident #2636-000010-16 related to responsive behaviours.
Log #015639-16, critical incident #2636-000013-16 related to a fall resulting in a change in condition.
Log #017131-16, critical incident #2636-000016-16 related to fall during a transfer resulting in injury.
Log #021944-16, critical incident #2636-000021-16 related to an injury during a transfer.
Log #027293-16, critical incident #2636-000013-16 related to a resident to resident altercation.
Log #027733-16, critical incident #2636-000024-16 related to resident to resident abuse.
Log #035063-16, critical incident #2636-000040-16 related to staff to resident abuse.
Log #033028-16, critical incident #2636-000030-16 related to resident to resident abuse.
Log #033029-16, critical incident #2636-000031-16 related to resident to resident abuse.
Log #000464-17, critical incident #2636-000001-17 related to resident to resident abuse.
Log #000590-17, critical incident #2636-000002-17 related to a medication error.
Log #000857-17, critical incident #2636-000007-15 related to a medication error.
Log #001129-17, critical incident #2636-000003-17 related to a medication error.
Log #001413-17, critical incident #2636-000005-17 related to a family complaint.
Log #001869-17, critical incident #2636-000007-17 related to a medication error.

This inspection was completed concurrently while in the home completing other inspections including:
Log #029609-16, critical incident #2636-000027-16 and log #031470-16, critical incident #2636-000007-13 - Inspection #2016_229213_0036
Log #022711-16, follow up to log #018577-16 and log #033528-16, follow up to log #002290-16 - Inspection #2016_229213_0038
Log #033550-16, critical incident #2636-000032-16 related to a fall with injury - Inspection #2016_303563_0042

Log #033908-16, critical incident #2636-000038-16 related a resident injury and log #034107-16, Infoline #IL-48359-LO, related to a family complaint regarding care - Inspection #2016_255633_0025
Log #002642-17 related to a complaint alleging abuse/neglect

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Administrator, the Director of Nursing, the Acting Director of Nursing, previous Administrators, previous Directors of Care, previous Assistant Directors of Nursing, previous Resident Care Coordinators, two Resident Care Coordinators, Regional Coordinators, the Vice President of Operations, the Vice President of Human Resources, the Corporate Communications Manager, a Corporate Executive Assistant, the Corporate Environmental Services Consultant, Consultant Pharmacists, a Pharmacy Clinical Lead, Physicians, Registered Nurses, Registered Practical Nurses, the Food and Nutrition Manager, a Registered Dietitian, a Program Manager, an Occupational Therapist, a Physiotherapist, a Physiotherapy Assistant, an Ontario Nurses Association Attorney, Personal Support Workers, an Administrative Assistant, a Scheduling Clerk, Ward Clerks, Maintenance staff, Housekeeping staff, family members and residents.

The Inspectors also observed resident care and medication practices and administration. The Inspectors reviewed electronic and paper health records, incident reports, education records, employee files, meeting minutes, complaint records, policies and procedures, program evaluations, and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's "Abuse & Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" policy with a review date of August 2016 stated:
"Mandatory Reporting: 1. All cases of suspected or actual abuse must be reported immediately in written form to the Director of Nursing (DON)/Administrator, and in the absence of management, to notify the charge nurse immediately who will contact manager on call." and,
"Staff-to-Resident Abuse: 4. The DON or in his/her absence the Charge Nurse, will complete a Head to Toe assessment of the resident and document the same".

a) The home submitted a Critical Incident (CI) System report to the Ministry of Health and Long Term Care (MOHLTC), related to a suspected incident of staff to resident abuse. A resident reported to a registered staff member that another staff member transferred the resident inappropriately causing minor injury, and that the registered staff noted minor injury. The resident was not able to elaborate regarding the time that it had occurred.

In an interview with the resident, they recalled being transferred by staff, that it hurt and that it caused minor injury.

Progress notes were reviewed in Point Click Care by the Inspector and a Resident Care Coordinator. No documentation was found related to the transfer or injury. Assessments were also reviewed in Point Click Care and there was no documentation of a Head to Toe or Skin Assessment completed for this resident.

In an interview with the registered staff member, they recalled the resident reporting the transfer and the minor injury, but did not recall if a progress note was completed, an assessment was done, or any documentation completed regarding the report of suspected abuse or the abuse. They could not recall if they spoke to anyone other than the resident and the Personal Support Workers regarding the incident or the injury when it was discovered.

In an interview with the Resident Care Coordinators (RCCs), one RCC said that a registered staff member advised them verbally of the incident and the injury when it was discovered and provided the information to the other RCC to submit a Critical Incident report to the MOHLTC. Both RCC's said that they did not have any documentation regarding the incident or the injury. A RCC said that a Head to Toe Assessment should have been completed and a report documented in writing when the registered staff member discovered the injury and staff to resident abuse was suspected.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with when a suspected abuse was not reported immediately in written form, and when a head to toe assessment was not completed and documented for a resident's injury.

b) The home submitted Critical Incident (CI) System report to the Ministry of Health and Long Term Care, related to an alleged incident of staff to resident abuse. The CI stated a resident reported to a registered staff member that staff on a specified date staff were rough during care. The registered staff member reported the incident to another registered staff member and the Director of Nursing.

The registered staff member acknowledged that all suspected or actual abuse was to be reported immediately to the DON or Resident Care Coordinator (RCC) and if the incident occurred after hours or on the weekend, incidents were to be reported to the manager on call. The registered staff member said the alleged incident of staff to resident abuse was not reported immediately when it occurred.

The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with when suspected abuse was not reported immediately in written form to the DON/Administrator or the manager on call. (563)

The severity of this non-compliance is minimal risk, the scope is wide spread. The home does have a history of non-compliance in this subsection of the legislation. It was issued as a Voluntary Plan of Correction on July 26, 2017. This was also issued as a Voluntary Plan of Correction in a concurrently completed critical incident inspection #2016_303563_0042, and as a Written Notification in currently completed critical incident inspection #2016_229213_0035, on January 24, 2017 [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. 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 the Ordering Medications Using the Best Possible Medication History (BPMH) Reconciliation/Admission Form policy was complied with.

O. Reg. 114 (2) states: "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home".

The home submitted a Critical Incident (CI) System report to the Ministry of Health and Long Term Care, related to a medication incident, for which the resident was taken to

hospital and resulted in a significant change in the resident’s health status.

The home's Medical Pharmacies policy #4-3, "Ordering Medications Using the Best Possible Medication History (BPMH) Reconciliation/Admission Form", dated January 2014, stated “indicate if drug is to be discontinued (X) and explain reason for discontinuing using legend on right. Additionally, clearly cross out the entire order in the order box to clearly indicate discontinuation and cross out any discontinued medications (includes duplicate orders) to clearly communicate currently maintained orders”.

Clinical records for a resident were reviewed. Progress notes documented in Point Click Care (PCC) for the resident, stated the Medication Reconciliation form was completed by a registered staff member and faxed to the physician. It was reviewed, completed and faxed back to the home. The physician discontinued two specific medications. The Medication Reconciliation form was faxed to the pharmacy, the orders were processed by the pharmacy, but the pharmacist did not note that the two medications were discontinued. The physician's orders were not double checked by registered nursing staff until two days later. Two registered staff members signed the Medication Reconciliation form to indicate that the orders were checked but did not note that the two medications were discontinued.

The resident continued to receive the discontinued medications for another 19 days and became ill. A registered staff member discovered the medication error that initially occurred when a subsequent Medication Reconciliation form was completed approximately four weeks later.

In an interview, a registered staff member said the Medication Reconciliation policy was not followed, which resulted in a medication error and the resident suffered ill effects.

The licensee failed to ensure that the Ordering Medications Using the Best Possible Medication History (BPMH) Reconciliation/Admission Form policy was implemented, as a resident continued to receive two discontinued medications for 19 days, which resulted in hospitalization.

The severity of this non-compliance is actual harm/risk and scope is isolated. The home does have a history of non-compliance in this subsection of the legislation. This was issued as a Voluntary Plan of Correction in May 2014, as a Written Notification in October 2014, and August 2014, and as a Voluntary Plan of Correction in October 2016. This was also issued as a Written Notification in a concurrently completed critical incident

inspection #2016_229213_0035. [s. 8. (1) (b)]

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. 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 :

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

The home submitted a Critical Incident (CI) System report to the Ministry of Health and Long Term Care, related to an incident where a resident sustained an injury while being transferred using a mechanical lift.

The "Caressant Care Nursing & Retirement Homes Ltd. Sling Attachment to Lifting Device" policy dated July 2016 stated: "Each staff member participating in the lift or transfer is to check each loop on both sides visually to ensure that each loop is correctly positioned on the lift and physically by ensuring the loop is positioned beyond the sling safety loop patched and cannot slip back".

Progress notes documented in Point Click Care (PCC) for a resident, stated while transferring a resident using transfer equipment, the resident suffered an injury.

In an interview with a staff member, and in reviewing of internal investigative records, the staff member said the transfer equipment procedure was not followed and the resident was lowered to the floor by staff.

In an interview the Director of Nursing (DON), the DON said the incident occurred as result of the mechanical lift procedure not followed by staff and acknowledged that the home's expectation was that each staff member was to follow the home's policy

regarding using a transfer equipment.

The licensee failed to ensure that staff used safe transferring techniques when assisting a resident using transfer equipment. [s. 36.]

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

The home submitted a Critical Incident (CI) System report to the Ministry of Health and Long Term Care, related to an incident where a resident sustained an injury, while using transfer equipment.

The home's internal investigation records were reviewed and written follow up action taken by the home stated specific procedures were not followed related to the transfer equipment.

Progress notes documented in Point Click Care for a resident stated a staff member suddenly was calling for help, other staff arrived, and a registered staff member noted immediately that the proper procedure had not been followed.

In an interview with a registered staff member, they said that the staff member assisting the resident had not followed the proper procedure. The registered staff member said that the home’s expectation was that staff used safe transferring and positioning devices or techniques when assisting residents, to prevent injury.

The licensee failed to ensure that staff used safe transferring techniques when assisting a resident. [s. 36.]

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

The home submitted a Critical Incident (CI) System report to the Ministry of Health and Long Term Care related to an incident of alleged staff to resident abuse. The CI stated a registered staff member noticed injury and that the resident stated to registered staff the description of staff member who transferred the resident causing minor injury.

The current plan of care in Point Click Care (PCC) related to transfers for the resident, stated extensive assistance for transfers with the use of a transferring device and two

persons was required for all transfers.

In an interview by Inspector #213 with the resident, the resident immediately remembered the incident, the transfer and the injury.

In an interview with the registered staff member, they said they noted the minor injury and that it appeared to have occurred during a transfer. The registered staff member said that this resident required two staff and the use of a transfer device, and likely this did not occur at the time of the incident. The registered staff member further explained that if there were two staff and a transfer device used for the transfer, injury would not occur.

The licensee failed to ensure that staff used safe transferring techniques when assisting a resident.

The severity of this non-compliance is minimal harm and the scope was a pattern. The home does not have a history of non-compliance in this subsection of the legislation. [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 #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are 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. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least annually, the matters referred to in O. Reg 53 (1) were evaluated and updated in accordance with evidence-based practices and there was a written record relating to each evaluation that includes: date of the evaluation, names of the persons who participated, summary of the changes made, and date that those changes were implemented.

The "Responsive Behavioural Program Evaluation" dated February 22, with no year identified, stated "Summary of changes made over the past year with date of change: Increase improvement with Behavioural Supports Ontario (BSO) and referring resident to outreach team. Geriatric Psych is coming to home. Education to staff and family. Implement post incident debrief", with no date when the changes were implemented as part of the responsive behavioural program.

In an interview, the Administrator said that the “Responsive Behavioural Program Evaluation” documented a summary of the changes made over the past year with no dates identifying when the changes were implemented.

In interviews, the BSO staff reviewed the copy of the "Responsive Behavioural Program Evaluation" where their name was listed as being a part of that evaluation and did not recall being a part of this evaluation.

The Administrator acknowledged that the responsive behaviour program evaluation was not evaluated by the people identified on the form and shared that the BSO staff denied being a part of the evaluation for February 2015-2016 time period.

The licensee has failed to ensure that at least annually, the matters referred to in O. Reg 53(1) related to responsive behaviours, were properly evaluated and updated in accordance with evidence-based practices. The written record relating to the evaluation did not include the year of the evaluation, names of the persons who participated, summary of the changes made with the date that those changes were implemented. [s. 53. (3)]

2. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

A) A Critical Incident (CI) System report was submitted to the Ministry of Health and Long Term Care (MOHLTC), related to an incident of staff to resident abuse on an identified date. The CI stated that a resident reported to a registered staff member that staff on a specified date staff were rough during care. The registered staff then reported to the Director of Nursing (DON) that the minor injury to the resident supported the resident's allegation of rough handling..

Progress notes documented in Point Click Care (PCC) included a Behaviour Exhibited note on an identified date that stated that a resident was very upset when the staff were assisting the resident. The note stated the resident got angry and the evaluation documented as part of this progress note stated, will monitor minor injury.

An "Incident Note Late Entry" on the identified date, stated each staff mentioned they continued to provide care despite recognizing the residents escalating behaviour.

During a telephone interview, a staff said that the resident initially allowed the two staff to provide care, but then the resident became very agitated and behaviours were escalating. The staff said staff did not feel the resident was safe to be left alone. The resident would let staff assist with a specific part of their care, but became agitated when staff attempted to assist with other specific parts of their care.

Multiple behaviours have been documented in the progress notes since the resident was admitted to the home. The current care plan identified a specific intervention for staff when the resident's behaviour escalated.. The staff providing care had access to the responsive behaviour care plan through Point of Care and did not implement the strategies to respond to these behaviours, where possible.

The licensee failed to ensure that strategies were implemented where possible to respond to a resident's behaviours. The resident had minor injuries noted three days after the resident reported rough care. The staff were to ensure the specific strategies to respond to these behaviours were implemented.

B) The home submitted a Critical Incident (CI) System report to the Ministry of Health and Long Term Care, related to an incident of resident to resident abuse on an identified date which caused injury to a resident.

The electronic health record was reviewed for an identified resident. Progress notes for the first two weeks after admission stated the resident had multiple responsive behaviours on multiple occasions during this time frame. The care plan the identified behaviour for this resident reflected these responsive behaviours.

An "Incident Note" documented in Point Click Care (PCC) on an identified date, stated one resident entered another resident's room and as a result of the resident's behaviour, the other resident sustained an injury. The care plan related to the identified behaviour was created 38 days after the incident.

The licensee failed to ensure that strategies were implemented where possible to respond to a resident's multiple behaviours towards other residents as care plan strategies were developed weeks after the behaviours were exhibited.

The severity of this non-compliance is minimal harm and the scope is isolated. The home does not have a history of non-compliance in this subsection of the legislation. This was

issued as a Voluntary Plan of Correction in a concurrently completed critical incident inspection #2016_229213_0042. [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that at least annually, the matters referred to in O. Reg 53 (1) are evaluated and updated in accordance with evidence-based practices and there is a written record kept relating to each evaluation that includes: date of the evaluation, names of the persons who participated, summary of the changes made, and date that those changes are implemented. Also, to ensure that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours where possible, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

The home submitted a Critical Incident (CI) System report to the Ministry of Health and Long Term Care related to family concerns regarding a resident.

The plan of care in Point Click Care (PCC) for the resident included two identified interventions. The electronic health record indicated that these interventions were not applicable to this resident and hadn't been since admission. In an interview with the resident, the resident agreed that these interventions were not appropriate and did not occur. Two registered staff members also confirmed that these interventions were not applicable to this resident.

The plan of care for this resident was not based on an assessment of the resident's needs and preferences.

The severity of this non-compliance is minimal risk and the scope scope is isolated. The home does not have a history of non-compliance in this subsection of the legislation. [s. 6. (2)]

2. The licensee has failed to ensure the resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

The following is additional evidence to support Compliance Order #004 identified in a concurrently completed critical incident inspection #2016_303563_0042 with a compliance date of March 1, 2017.

a) The home submitted a Critical Incident (CI) System report to the Ministry of Health and Long Term Care (MOHLTC), related to an incident of resident to resident abuse causing injury.

The current care plan for the first resident identified a particular intervention. The identified interventions were observed not in place.

The Resident Assessment Instrument Coordinator (RAI-C) and Inspector #563 made observations together and the RAI-C acknowledged that the interventions were not in place. At that time two staff members said that the interventions were not being utilized for months, as they were no longer effective. The RAI-C acknowledged that the resident was not reassessed and the care plan was not revised when this intervention was no longer effective.

A resident was not reassessed and the plan of care was not reviewed or revised when interventions were no longer necessary or effective.

b) The home submitted a Critical Incident (CI) System report to the MOHLTC, related to an incident of resident to staff abuse. The CI stated that a registered staff member charted that staff were providing care when the resident's behaviour escalated towards staff. The resident reported to registered staff that staff were rough during care.

An Incident Note in Point Click Care (PCC) stated the resident became upset and required a particular intervention. The care plan intervention in the resident's care plan to direct staff regarding a specific intervention was implemented nine days after the resident voiced concerns and not at the time when the resident's care needs changed.

In interviews, the Resident Assessment Coordinators and the Behaviour Support staff in the home said that they were aware of the incident and that the care plan should have been updated at the time and not several days later.

The licensee failed to ensure that a resident was reassessed and the plan of care was reviewed when the resident voiced concerns related to a specific need and intervention. The care plan was not revised until nine days after the resident's care needs changed and after the incident reported in the critical incident occurred.

The severity of this non-compliance is potential for harm or risk of harm and the scope is isolated. The home does not have a history of non-compliance in this subsection of the legislation. This was issued as Compliance Order #004 in a concurrently completed critical incident inspection #2016_303563_0042 with a compliance date of March 1, 2017. [s. 6. (10) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways were kept closed and locked, equipped with a door access control system kept on at all times, equipped with an audible door alarm, and was connected to the resident-staff communication and response system or connected to an audio visual enunciator.

On February 8, 2017 at 1215 hours, Inspectors #137, #213 and #563 observed a stairwell near the Director of Nursing office in a resident home area on the first floor "B" unit, labelled "to the retirement home". This area was open by way of two double doors

that were magnetically held open as well as another door which was closed, but not locked leading to the south wing resident home area. The stairwell was closed by a wooden gate measuring 143 centimeters (cm) wide by 73.5 cm high, with a space between the floor and the bottom of the gate measuring 27 cm high. The gate was not locked, but closed with a simple push button latch on the inside of the gate. The stairwell lead to the basement/lower level of the home which in turn lead to a door to the exterior of the home that was not locked, had no door access control system and was not equipped with an audible door alarm. There were two signs on the exterior side of the wooden gate, one was red and stated "DANGER" and the other sign was white outlined in red and stated "EMPLOYEES ONLY". On the stairwell side of the wooden gate there was a sign that stated "SHUT AND LATCH GATE FOR SAFETY REASONS THANK YOU". There was a sign on the wall on the right, on the wall beside the exterior of the gate that stated "STOP. STAFF ONLY BEYOND THIS POINT". On the wall on the left beside the exterior of the gate, there was a sign that stated "SHUT AND LATCH GATE FOR SAFETY REASONS. THANK YOU". A resident was observed sitting in a chair at a table across and approximately two meters from the gated stairwell, at the time of the stairwell observation.

Inspector #137 left to alert management of the home while Inspectors #213 and #563 stayed to monitor the stairwell to ensure the safety of residents. During this time, a resident opened one of the two double doors and walked through the doors with ease, using an assistive device, to the stairwell area. The Inspectors attempted to communicate with the resident and found the resident was pleasantly confused and unable to communicate or follow direction. The resident then left the area following a staff member out. Staff were coming and going from the nursing home area through to the retirement home area while the Inspectors waited monitoring the area.

In an interview with the Administrator, the Acting Director of Nursing and a Resident Care Coordinator, all three stated that the stairwell was not secured with a door that was locked or able to be locked, not equipped with a door access control system, not equipped with an audible door alarm, not connected to the resident-staff communication and response system or connected to an audio visual enunciator. They said that residents did access that area on a daily basis and had access to the stairwell as well as the door to the exterior in the basement.

The severity of this non-compliance is minimal harm/potential for harm/risk and the scope is isolated. The home does not have a history of non-compliance in this subsection of the legislation. [s. 9. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported was immediately investigated and that appropriate action was taken in response to every such incident.

The following is additional evidence to support Compliance Order #003 identified in a concurrently completed critical incident inspection #2016_303563_0042 with a compliance date of March 1, 2017.

1. The home submitted a Critical Incident (CI) System report to the Ministry of Health and Long Term Care (MOHLTC), related to a suspected incident of staff to resident abuse that occurred the day prior. The CI stated that the resident reported an injury that occurred during a transfer. A registered staff member noticed the injury and that the resident provided a description of staff member who transferred the resident causing minor injury.

In an interview with the resident recalled the incident that it hurt, and that it caused injury.

During the interview, injury was noted. The resident was unable to recall the date of the incident.

Progress notes were reviewed in Point Click Care by Inspector #213 and the Resident Care Coordinator (RCC). No documentation was found related to the resident's allegation or injury noted in the critical incident.

In a phone interview with the registered staff member, they said they did not recall the date of the incident or if a progress note was made regarding the incident. The registered staff member recalled the injury and noting that it appeared consistent with occurring during a transfer. The registered staff member later said there was no documentation in the progress notes that described the injuries to the resident or the follow up related to the reported incident. The registered staff said that staff would not know about the injury for monitoring because there was no progress note completed. The CI report indicated continuing to monitor injury; however, the injury and the monitoring was not documented in the resident's clinical record in Point Click Care.

In an interview with the Director of Nursing (DON), the DON said that a Resident Care Coordinator (RCC) submitted the CI and spoke to the resident regarding the incident. The DON said that they had not been able to arrange an interview to date with the staff member suspected in the incident, that this staff member had continued to work since the incident and that no further action had been taken to date.

In an interview with the RCCs, one RCC said that a registered staff member reported the allegation to them and that they and the registered staff spoke to the resident about the suspicion right away. The RCC was aware of the incident and the injury, but the information was provided to the other RCC to submit a CI report to the MOHLTC. The first RCC said that no further investigation or follow up was done related to this incident. The second RCC said that they submitted the incident in a CI report to the MOHLTC, but did not complete any further investigation or follow up related to the incident.

In an interview with the Acting Administrator, they said that they were aware of the reported suspicion of abuse involving the resident. The Acting Administrator said they were aware that the staff member suspected in the incident had not been interviewed to date, that this staff member had continued to work since the incident and that no further action had been taken to date.

The licensee failed to immediately investigate the suspected staff to resident physical

abuse of a resident or take appropriate actions. [s. 23. (1)]

2. a) The home submitted Critical Incident (CI) System report to the Ministry of Health and Long Term Care, related to an incident of resident to resident physical abuse on an identified date. Actions taken and documented as part of the care given stated, a Head to Toe Assessment was completed.

Record review of the completed Head to Toe Assessments in Point Click Care (PCC) was completed, and at the time of the incident, a Heat To Toe Assessment was not completed as stated in the CI.

In an interview with the Resident Assessment Instrument Coordinator (RAI-C), they said a Head to Toe Assessment was not completed in PCC for resident.

In an interview with a registered staff member, they said one resident sustained an during an altercation with another resident. The Critical Incident Report stated that the registered staff completed a Head to Toe Assessment of the resident and noted minor injury. The registered staff member signed into Point Click Care and said a Head to Toe Assessment was not completed, only a visual head to toe assessment was done.

b) The CI also identified other actions had been taken to prevent re-occurrence.

The current care plan for the first resident indicated a particular intervention related to the incident and it required documentation. Record review of the Point of Care (POC) tasks in PCC included the intervention and this was documented hourly by the Personal Support Workers (PSWs). The care plan in PCC related to another intervention for this resident was added to this resident's care plan and removed when it was no longer necessary.

The care plan in PCC for the other resident was reviewed, and the interventions identified in the CI report was not found in the plan of care for current or resolved interventions and the interventions were not documented in POC tasks by the PSWs.

A Resident Assessment Instrument Coordinator (RAI-C) said there was no intervention added to the second resident's care plan and that the other identified intervention was not documented as part of the tasks in POC as being completed.

The licensee failed to ensure that the appropriate action documented as part of the CI

report was taken in response to the resident to resident physical abuse.

The severity of this non-compliance is minimal risk, the scope is wide spread with one out of one resident affected. The home has a history of non-compliance in this subsection of the legislation; it was issued as a voluntary plan of correction on October 20, 2016. This was also issued as Compliance Order #003 in a concurrently completed inspection #2016_303563_0042 with a compliance date of March 1, 2017. [s. 23. (1) (b)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone, or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

The following is additional evidence to support Compliance Order #002 identified in a concurrently completed follow up inspection #2016_229213_0038 with a compliance date of January 27, 2017.

a) The home submitted a Critical Incident (CI) System report to the Ministry of Health and Long Term Care, related to a suspected incident of staff to resident abuse that occurred on an identified date. The CI stated that the resident reported an injury that occurred during a transfer. A registered staff member noticed the injury and that the resident provided a description of staff member who transferred the resident causing minor injury.

In an interview with the resident, they recalled the incident, that it hurt, and that it caused injury. During the interview, injury was noted. The resident was unable to recall the date of the incident.

In an interview with the Resident Care Coordinators (RCC), one RCC said that a registered staff member reported the allegation to them immediately after the resident told the the registered staff member about it, and that the RCC and the registered staff spoke to the resident about the suspicion right away that day. The RCC was aware of the incident and the injury, but did not have access to the Ministry of Health and Long Term Care Critical Incident System and had not used it yet, so provided the information to the other RCC to submit the report. The first RCC said that they had no documentation of the incident or the conversation with the resident, could not recall the date of the incident or the date they provided the information to the other RCC to submit the Critical Incident report to the Director. Both RCC's agreed and said that according to the critical incident report, the Director was notified of the suspicion of physical abuse 28 hours after the incident was reported to the home and not immediately.

Progress notes were reviewed in Point Click Care by Inspector #213 and the RCC. No documentation was found related to the resident’s allegation or injury noted in the critical incident. In a phone interview with the registered staff member, they said they did not recall the date of the incident or if a progress note was made regarding the incident. The registered staff member recalled the injury and noting that it appeared consistent with occurring during a transfer. In an interview with both RCCs, one RCC said that they did not retain the documentation received from the RCC regarding the suspicion of physical abuse from the resident.

In an interview with the Acting Administrator, the Acting Administrator said that they were aware of the reported suspicion of abuse involving the resident and agreed that the Critical Incident was not immediately reported to the Director.

The home failed to immediately report a suspicion of staff to resident physical abuse of a resident to the Director, when it was reported to a a registered staff member, and a

Resident Care Coordinator. [s. 24. (1)]

b) The home submitted a Critical Incident (CI) System report to the Ministry of Health and Long Term Care on an identified date, related to an incident of resident to staff abuse that occurred two days prior to the report. The CI stated that a registered staff member charted that the resident was very upset when Personal Support Workers (PSW)s were providing care when the resident's behaviour escalated towards staff. The resident reported to a registered staff member that staff were rough during care. The CI was reported as resident to staff abuse and not staff to resident abuse.

The Administrator acknowledged that the description of the unusual occurrence stated that the injury the resident sustained was consistent with the resident's report and this was an example of staff to resident suspected physical abuse and not resident to staff. The Administrator acknowledged a CI related to the suspected staff to resident physical abuse of resident was not reported to the Director.

The home failed to immediately report a suspicion of staff to resident physical abuse of a resident to the Director, when it was reported to the home.

The severity of this non-compliance is minimum risk, the scope is isolated. The home has a history of non-compliance in this subsection of the legislation; a compliance order was issued on November 25, 2015 and was reissued on October 20, 2016 with a compliance date of October 31, 2016. This area of non-compliance was re-issued as Compliance Order #002 in a concurrently completed follow up inspection #2016_229213_0038 with a compliance date of January 27, 2017. [s. 24. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The following is additional evidence to support Compliance Order #001 identified in a concurrently completed critical incident inspection #2016_303563_0042 with a compliance date of March 1, 2017.

a) A "Physical Aggression Received" progress note documented in Point Click Care (PCC), stated one resident entered another resident's room and as a result of the resident's behaviour, the other resident sustained an injury.

In an interview, Resident Assessment Instrument Coordinator (RAI-C) said that all skin and wound assessments were completed in the Pixalere electronic documentation system and no other means of documentation in the resident's clinical record demonstrated that an assessment was completed. Pixalere was specifically designed for skin and wound assessments and acts as a clinically appropriate assessment instrument capturing all appropriate skin and wound documentation, monitoring, assessment and treatment.

The RAI-C said there was nothing documented in Pixalere related to the injury sustained and there was no treatment plan started. The RAI-C said that the resident should have received a skin assessment by a member of the registered nursing staff using the Pixalere documentation system.

b) A "Physical Aggression Received" progress note documented in PCC, described an incident of resident to resident physical aggression causing injury.

In an interview, a RAI-C said there was nothing documented in Pixalere related to the injury sustained, and there was no treatment plan started. The RAI-C shared that the resident should have received a skin assessment by a member of the registered nursing staff using the Pixalere documentation system. The RAI-C said it was the home’s expectation to complete a skin assessment in Pixalere for the identified injuries sustained by the resident.

C) An "Incident Note" documented in PCC stated a resident suffered an injury with altered skin integrity.

The RAI-C said there was nothing documented in Pixalere related to the injury sustained and there was no treatment plan started. The RAI-C also said the wound care nurse would not know that the injury existed as the incident was documented under an incident note and not under a skin and wound note in PCC and there was nothing documented or monitored in Pixalere.

The licensee failed to ensure that the resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

The severity of this non-compliance is potential for harm/risk and the scope is widespread with two out of two residents affected. The home has a history of non-compliance in this subsection of the legislation, it was issued as a Voluntary Plan of Correction during the RQI December 8, 2014. This was also issued as Compliance Order #001 in a concurrently completed critical incident inspection #2016_303563_0042. [s. 50. (2) (b) (i)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure there were procedures and interventions developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

The home submitted a Critical Incident (CI) System report to the Ministry of Health and Long Term Care, related to an incident of resident to resident abuse. An identified resident had previous altercations with other residents on three occasions.

The home's "Resident Behaviour Management" policy with a review date of July 2016, stated the procedure for any resident exhibiting a behaviour that staff have identified as disruptive or potentially injurious to the resident or others, a Responsive Behaviour Tracking Record would be initiated and completed over 72 hours. The policy stated the multidisciplinary team would also complete the Responsive Behaviour Checklist for Potential Triggers.

In interviews with Behavioural Supports Ontario (BSO) registered staff member, another two registered staff members, and the Resident Assessment Instrument Coordinators (RAI-C), they said they have never seen the "Responsive Behaviour Tracking Record" or the "Responsive Behaviour Potential Triggers-Checklist" before and have not used these

tools to document responsive behaviours. The procedure outlined in the "Resident Behaviour Management" Policy was not implemented. All registered staff interviewed said the Dementia Observation System (DOS) charting was used, and that potential triggers were not identified using the form outlined in the policy. The "Responsive Behaviour Tracking Record" and the "Responsive Behaviour Potential Triggers-Checklist" were not used to identify risk, the frequency or the disruptiveness of responsive behaviours to minimize risk of altercations.

The paper chart and clinical records for the resident were reviewed and the "Responsive Behaviour Tracking Record" and the "Responsive Behaviour Potential Triggers-Checklist" were not completed when resident exhibited a behaviour injurious to another resident.

The "Responsive Behavioural Program Evaluation" for the review period of February 2015 to February 2016 was completed on February 22 with no identified year documented. Criteria “4” on the evaluation stated, "is the documentation complete following an episode by a resident who is exhibiting inappropriate behaviour?" with a response of "yes" and "no" with a hand written comment that stated, "most of time". Criteria “7” on the evaluation stated, "are residents and staff who have been harmed by a resident during an episode of inappropriate behaviour, been supported?" with a response of "no" and a hand written comment that stated, "we have started doing post incident debrief". The "summary of changes made over the past year with date of change" stated "increase improvement with BSO and referring resident to outreach team. Geriatric Psych is coming to home. Education to staff and family. Implement post incident debrief". The evaluation was reviewed with Administrator #160 on February 13, 2017, and the Administrator said that the changes were not specific, did not include new interventions or procedures to improve criteria #4 or #7 and said the areas of improvement outlined on the evaluation were vague. Administrator #160 also said a post incident debrief did not support the resident or staff harmed by a resident during an episode of inappropriate behaviour.

The licensee failed to ensure that the procedures to complete the "Responsive Behaviour Tracking Record" and the "Responsive Behaviour Potential Triggers-Checklist" as outlined in the "Resident Behaviour Management" policy were implemented to identify potential triggers. The "Responsive Behavioural Program Evaluation" dated February 2016 did not document interventions developed to support the resident or staff harmed as a result of a resident's behaviours. The documentation tools as part of the policy were not used to identify triggers to minimize the risk of altercations and potentially harmful

interactions between and among residents.

The severity of this non-compliance is minimum risk and the scope is isolated. The home does not have a history of non-compliance in this subsection of the legislation. [s. 55. (a)]

WN #11: 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. (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:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
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).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure the Director was informed of the analysis and follow-up action, including the immediate actions that were taken to prevent recurrence and the long-term actions planned to correct the situation and prevent recurrence, related to an incident that caused an injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident's health status.

The home submitted Critical Incident (CI) System report to the Ministry of Health and Long Term Care (MOHLTC), related to an incident that caused an injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident's health status. Under the analysis and follow-up section of the CI, and what immediate actions were taken to prevent recurrence, the home stated resident's safety plan would be reviewed with family and incident was under investigation. Under what long-term actions were planned to correct this situation and prevent recurrence, the home stated ongoing education.

An amendment to the CI report was requested for further information in more detail, by a Triage Inspector at the MOHLTC. Approximately eight months after the submission of the CI report and further information was requested, during a review of the MOHLTC CI system, there was no documentation added to the CI indicating that an amendment was completed by the home as requested.

In an interview, the Director of Nursing told Inspector #137 that an amendment had not been completed and submitted for CI #2636-000013-16, as requested and required by legislative requirements.

The severity of this non-compliance is minimum risk and the scope is isolated. The home does not have a history of non-compliance in this subsection of the legislation. [s. 107. (4)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered in accordance with the directions for use specified by the prescriber.

The following is additional evidence to support Compliance Order #901 identified in a concurrently completed critical incident inspection #2016_229213_0035 with a compliance date of January 27, 2017.

a) The home submitted Critical Incident (CI) System report to the Ministry of Health and Long Term Care (MOHLTC), related to a medication incident involving a resident.

Progress notes documented in Point Click Care (PCC) for the resident stated the resident developed a health condition and was prescribed a medication for seven days.

The electronic medication administration records (eMAR) for the resident stated eight doses of the prescribed medication were missed, one at the beginning of the course of treatment and seven doses at the end of the treatment. A registered staff member documented the code "10" on the eMAR, indicating the medication was not available.

The home's internal investigation records contained follow up documentation that stated there was a starter pack in the home's emergency drug box that was available and was not utilized, and the pharmacy did not send the full prescription for the prescribed medication.

Inspector #137 observed two starter packs of the prescribed medication, each containing six tablets, in the home's emergency drug box.

In an interview, a registered staff member said they were not aware that there was a starter pack in the emergency drug box for the prescribed medication and that they did not follow up with the pharmacy, resulting in the resident missing eight doses of the prescribed medication.

The licensee failed to ensure that drugs were administered in accordance with the directions for use specified by the prescriber as a resident missed eight doses of a prescribed medication, one at the beginning of the course of treatment and seven doses at the end of the treatment.

b) The home submitted CI report to the MOHLTC, related to a medication incident involving a resident.

A registered staff member received an order for a medication for a resident, they wrote it in the progress notes and not on the physician's order form. As a result, the order was not processed and the medication was not received. The resident did not receive the prescribed medication until three days after the medication was ordered after the resident asked another registered staff member about the medication.

The licensee failed to ensure that drugs were administered in accordance with the directions for use specified by the prescriber as a resident had an infection and did not receive the prescribed medication until three days after it had been prescribed by the physician.

The severity of this non-compliance was actual harm/risk and the scope was widespread with two out of two residents affected. The home does not have a history of non-compliance in this subsection of the legislation, but it was issued as compliance order #901 in a concurrently completed critical incident inspection #2016_229213_0035. [s. 131. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's written record was kept up to date at all times.

The home submitted Critical Incident (CI) System report to the Ministry of Health and Long Term Care, related to an incident for a resident on an identified date. The CI documented that the incident was reported to the resident's family member's spouse as the family member was not home.

A "Family Note" in progress notes in Point Click Care (PCC) stated Power of Attorney (POA) furbished a cell number if need to contact them.

An "Incident Note" in PCC, stated the registered staff member attempted to call POA but was not home. The resident's contact information was not updated as part of the clinical record in the "Profile" section of PCC, The resident "Profile" in PCC did not have the POA's cell number documented.

The Resident Assessment Instrument Coordinator (RAI-C) said the expectation was that contact information was updated in the Profile section of PCC at the time of the change and said additional information would also be added in a note in the Profile if necessary. The "Profile" in PCC was the point of access for resident, family, and POA contact information for staff.

The licensee failed to shall ensure that the resident's written record was kept up to date at all times when the POA provided to the home with a cell phone number. The profile was not updated with the POA's cell number and there had been multiple calls to the POA at home where they could not be reached.

The severity of this non-compliance is minimum risk and the scope is isolated. The home does not have a history of non-compliance in this subsection of the legislation. [s. 231. (b)]

Issued on this 18th day of July, 2017

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

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

Ministére 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) :	RHONDA KUKOLY (213), MARIAN MACDONALD (137), MELANIE NORTHEY (563), SHERRI COOK (633
Inspection No. / No de l'inspection :	2016_229213_0039
Log No. / Registre no:	004840-16, 008948-16, 015639-16, 017131-16, 021944-16, 027293-16, 027733-16, 033028-16, 033029-16, 035063-16, 000464-17, 000590-17, 000857-17, 001129-17, 001413-17, 001869-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 24, 2017
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 WOODSTOCK NURSING HOME 81 FYFE AVENUE, WOODSTOCK, ON, N4S-8Y2
	Angel Roth

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

Ministére 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

Name of Administrator /
Nom de l'administratrice
ou de l'administrateur :

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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 will ensure that the home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

Specifically, the licensee will ensure that all staff of the home who have not already received the following education in 2017, are educated regarding the home's written policy that promotes zero tolerance of abuse and neglect, including:
- definitions
- measures and strategies to prevent abuse and neglect
- the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care
- situations that may lead to abuse and neglect and how to avoid such situations
- mandatory reporting
- whistle blowing protection
- individual role responsibilities
- related forms and tools
- the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of an investigation
- procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected
- consequences, procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents.

The home will also develop and implement a process for tracking staff education including dates completed by each staff member, to ensure completion of the education.

Grounds / Motifs :

1. (563)

2. 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 home's "Abuse & Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" policy with a review date of August 2016 stated:
"Mandatory Reporting: 1. All cases of suspected or actual abuse must be

reported immediately in written form to the Director of Nursing (DON)/Administrator, and in the absence of management, to notify the charge nurse immediately who will contact manager on call." and,

"Staff-to-Resident Abuse: 4. The DON or in his/her absence the Charge Nurse, will complete a Head to Toe assessment of the resident and document the same".

a) The home submitted a Critical Incident (CI) System report to the Ministry of Health and Long Term Care (MOHLTC), related to a suspected incident of staff to resident abuse. A resident reported to a registered staff member that another staff member transferred the resident inappropriately causing minor injury, and that the registered staff noted minor injury. The resident was not able to elaborate regarding the time that it had occurred.

In an interview with the resident, they recalled being transferred by staff, that it hurt and that it caused minor injury.

Progress notes were reviewed in Point Click Care by the Inspector and a Resident Care Coordinator. No documentation was found related to the transfer or injury. Assessments were also reviewed in Point Click Care and there was no documentation of a Head to Toe or Skin Assessment completed for this resident.

In an interview with the registered staff member, they recalled the resident reporting the transfer and the minor injury, but did not recall if a progress note was completed, an assessment was done, or any documentation completed regarding the report of suspected abuse or the abuse. They could not recall if they spoke to anyone other than the resident and the Personal Support Workers regarding the incident or the injury when it was discovered.

In an interview with the Resident Care Coordinators (RCCs), one RCC said that a registered staff member advised them verbally of the incident and the injury when it was discovered and provided the information to the other RCC to submit a Critical Incident report to the MOHLTC. Both RCC's said that they did not have any documentation regarding the incident or the injury. A RCC said that a Head to Toe Assessment should have been completed and a report documented in writing when the registered staff member discovered the injury and staff to resident abuse was suspected.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with when a suspected abuse was not reported immediately in written form, and when a head to toe assessment was not completed and documented for a resident's injury.

b) The home submitted Critical Incident (CI) System report to the Ministry of Health and Long Term Care, related to an alleged incident of staff to resident abuse. The CI stated a resident reported to a registered staff member that staff on a specified date staff were rough during care. The registered staff member reported the incident to another registered staff member and the Director of Nursing.

The registered staff member acknowledged that all suspected or actual abuse was to be reported immediately to the DON or Resident Care Coordinator (RCC) and if the incident occurred after hours or on the weekend, incidents were to be reported to the manager on call. The registered staff member said the alleged incident of staff to resident abuse was not reported immediately when it occurred.

The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with when suspected abuse was not reported immediately in written form to the DON/Administrator or the manager on call. (563)

The severity of this non-compliance is minimal risk, the scope is wide spread. The home does have a history of non-compliance in this subsection of the legislation. It was issued as a Voluntary Plan of Correction on July 26, 2017. This was also issued as a Voluntary Plan of Correction in a concurrently completed critical incident inspection #2016_303563_0042, and as a Written Notification in currently completed critical incident inspection #2016_229213_0035, on January 24, 2017 [s. 20. (1)]

(213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2017

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. 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 will ensure that the medication management system written policies and protocols are implemented. Specifically, the the licensee will ensure:
a) Policy #4-3, Ordering Medications Using the Best Possible Medication History (BPMH) Reconciliation/Admission Form, is reviewed and revised as necessary.
b) All registered staff are educated regarding the Ordering Medications Using the Best Possible Medication History (BPMH) Reconciliation/Admission Form policy and use of the form.
c) The home will develop and implement a process for tracking staff education including dates completed by staff, to ensure completion.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the Ordering Medications Using the Best Possible Medication History (BPMH) Reconciliation/Admission Form policy was complied with.

O. Reg. 114 (2) states: "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home".

The home submitted a Critical Incident (CI) System report to the Ministry of Health and Long Term Care, related to a medication incident, for which the

resident was taken to hospital and resulted in a significant change in the resident ’s health status.

The home's Medical Pharmacies policy #4-3, "Ordering Medications Using the Best Possible Medication History (BPMH) Reconciliation/Admission Form", dated January 2014, stated “indicate if drug is to be discontinued (X) and explain reason for discontinuing using legend on right. Additionally, clearly cross out the entire order in the order box to clearly indicate discontinuation and cross out any discontinued medications (includes duplicate orders) to clearly communicate currently maintained orders”.

Clinical records for a resident were reviewed. Progress notes documented in Point Click Care (PCC) for the resident, stated the Medication Reconciliation form was completed by a registered staff member and faxed to the physician. It was reviewed, completed and faxed back to the home. The physician discontinued two specific medications. The Medication Reconciliation form was faxed to the pharmacy, the orders were processed by the pharmacy, but the pharmacist did not note that the two medications were discontinued. The physician's orders were not double checked by registered nursing staff until two days later. Two registered staff members signed the Medication Reconciliation form to indicate that the orders were checked but did not note that the two medications were discontinued.

The resident continued to receive the discontinued medications for another 19 days and became ill. A registered staff member discovered the medication error that initially occurred when a subsequent Medication Reconciliation form was completed approximately four weeks later.

In an interview, a registered staff member said the Medication Reconciliation policy was not followed, which resulted in a medication error and the resident suffered ill effects.

The licensee failed to ensure that the Ordering Medications Using the Best Possible Medication History (BPMH) Reconciliation/Admission Form policy was implemented, as a resident continued to receive two discontinued medications for 19 days, which resulted in hospitalization.

The severity of this non-compliance is actual harm/risk and scope is isolated. The home does have a history of non-compliance in this subsection of the

legislation. This was issued as a Voluntary Plan of Correction in May 2014, as a Written Notification in October 2014, and August 2014, and as a Voluntary Plan of Correction in October 2016. This was also issued as a Written Notification in a concurrently completed critical incident inspection #2016_229213_0035. [s. 8. (1) (b)] (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2017

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 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 24th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RHONDA KUKOLY

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