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
Oct 18, 2019	2019_722630_0017 (A1)	006306-19, 007718-19, 008413-19, 010025-19, 012449-19, 012912-19	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 Woodstock Nursing Home
81 Fyfe Avenue WOODSTOCK ON N4S 8Y2

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

Amended by AMIE GIBBS-WARD (630) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee requested and Ministry approved extension due date from October 31, 2019 to November 30, 2019.
For CO #001 section 6 (1), for education on care planning and review of new policies to support the success of section (a) and (b).
For CO #002 section 8 (1), to reach full education of staff listed in section (b).

Issued on this 18th day of October, 2019 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by AMIE GIBBS-WARD (630) - (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): July 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17 and 18, 2019.

The following Critical Incident (CI) intakes were completed within this inspection:

Related to the prevention of abuse and neglect:

Log #006306-19 / CI 2636-000023-19

Log #010025-19 / CI 2636-000045-19

Related to an unexpected death:

Log #012449-19 / CI 2636-000050-19

Log #012912-19 / CI 2636-000053-19

Related to falls prevention

Log #007718-19 / CI 2636-000027-19

Log #008413-19 / CI 2636-000035-19

Documentation of non-compliance related to Complaint Inspection #2019_722630_0018 for Log #012885-19 has been included within this Critical Incident System Inspection Report.

Documentation of non-compliance related to CI Log #012912-19 and Log

#010025-19 have also been documented in Follow-up Inspection 2019_722630_0016.

During the course of the inspection, the inspector(s) spoke with the Caressant Care Vice President of Operations, the Caressant Care Regional Director Long-Term Care, the Caressant Care Director of Clinical Services and Education, the OMNI Chief Operating Officer, the OMNI Lead Education/On-site Representative, the Executive Director (ED), the Director of Care (DOC), the Assistant Director of Care (ADOC), a Resident Care Coordinator (RCC), Resident Assessment Instrument (RAI) Co-ordinators, the Nutrition Manager, a Physiotherapist (PT), a MediGas Respiratory Therapist (RT), a MIP Senior Account Manager, a Pinkerton Operations Manager, a Ward Clerk, Registered Nurses (RNs), Registered Practical Nurses (RPNs), agency RNs, agency RPNs, Personal Support Workers (PSWs), Housekeepers, family members and residents.

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation

During the course of the original inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out: (a) the planned care for the resident; (b) the goals the care

was intended to achieve; and (c) clear directions to staff and others who provided direct care to the residents related to oxygen therapy.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date. This report stated that an identified resident had a fall and they were found without their oxygen therapy in place.

The clinical record for this identified resident showed the resident had been using oxygen therapy after their admission to the home on a specific date. The record did not include a documented assessment by a Respiratory Therapist after their admission to the home regarding oxygen therapy, a physician's order for oxygen, the documentation of oxygen care provided in the home within the electronic Medication Administration Record (eMAR) or consistently in the progress notes or regular monitoring of the resident's oxygen saturation levels.

During an interview with an identified registered staff member they told Inspector #630 that if a resident was on oxygen therapy prior to admission most of the time there should be an order for oxygen and the nurses would assess vitals for the first three days. The staff member said they could apply oxygen therapy to a resident as a nursing measure and there should be a physician order but sometimes this had been forgotten at admission. The staff member said that automatically they would keep the resident on the oxygen at the level they were admitted on. When asked how often residents' oxygen saturation levels were to be checked if they were on oxygen therapy, the staff member said that there was not a standard frequency it was just common sense. The staff member said that in the home the Personal Support Workers (PSWs) were allowed to put the oxygen on and could get the tanks and they felt the PSWs lacked knowledge about this therapy. The staff member said they had been familiar with this identified resident and staff had provided oxygen therapy to the resident. The staff member said based on the location of the resident's room it was hard to monitor the resident. The staff member said the resident did not have their oxygen on at the time of the CI that had been reported to the MOHLTC.

During interview with another staff member they said they were familiar with this resident and this resident required oxygen therapy and required specific interventions from staff.

During an interview another registered nursing staff member told Inspector #630

that they could initiate oxygen therapy for residents based on the medical directive for oxygen use and then they would notify the physician. The staff member said that if a resident required oxygen on an ongoing basis they would need to follow an order from the physician. The staff member said it was the expectation in the home that oxygen therapy would be included in the plan of care. The staff member said that the frequency of checking a resident's oxygen saturation levels would depend on clinical signs such as confusion. The staff member said they were familiar with this resident and this resident had required a specific oxygen therapy.

During an interview a Respiratory Therapist (RT) said that Caressant Care Woodstock had a contract with their company to provide oxygen equipment and for the RT to do assessments of the residents' oxygen therapy for the funding. The RT said that the only way they would know that a resident had been admitted to the home on oxygen therapy was if the home faxed or telephoned them a referral. The RT said they had not received a referral from the home regarding this resident and they had not been assessed by the RT after admission regarding their oxygen therapy requirements. The RT said it was the expectation in the home that oxygen therapy would be included in a resident's physician orders.

During an interview the Director of Care (DOC) and the Assistant Director of Care (ADOC) said they had both started in their current respective roles less than two weeks ago. When asked if they were familiar with the processes in the home for oxygen therapy, they said it was just what they had covered that day reviewing the policies. They said it would be expected that oxygen therapy would be included as part of the physician's order, the eMAR or eTAR and the plan of care. Inspector #630 reviewed the documentation for this resident with the DOC and ADOC and they acknowledged that there was no physician order, medical directive or plan of care for staff that provided clear direction to staff regarding the resident's oxygen therapy. When asked how often staff would be expected to have checked the resident's oxygen saturation levels, they said that staff would be expected to do it if there were signs of symptoms of desaturation and acknowledged this was not part of the plan of care. They also acknowledged that the plan of care did not provide clear direction regarding the desired oxygen saturation levels for this resident or other goals of oxygen therapy for this resident.

B) The home submitted another CIS report to the MOHLTC on a specific date. This report stated that an identified resident had been "oxygen dependent."

The clinical record for this identified resident showed this resident had been using oxygen therapy. The clinical record for this resident included a written order from the physician with a specific date which was not process until a week after it was written. This order did not include a specific prescribed oxygen level and instead stated that the resident was to be on oxygen to maintain oxygen saturation levels above 92 per cent. There were several documented vital signs for specific dates where the resident's oxygen saturation levels were less than 92 per cent and the actions taken by the staff in the home in response to those levels were not consistently documented. There was also no documentation of the oxygen care provided to the resident for a specific time frame within the eMAR or eTAR.

During an interview an identified registered nursing staff member told Inspector #630 that they were familiar with this resident and they required specific interventions. This staff member said they thought the resident needed a reassessment by the RT and had requested a referral from the physician. The staff member said they did not know what happened with the RT referral. This staff member and Inspector #630 reviewed the physician's orders for this resident and the staff member acknowledged that there was no order for oxygen and said that oxygen could be applied as a nursing measure. The staff member said they thought the resident's need for oxygen therapy required more than just the oxygen as a nursing measure.

During an interview the Respiratory Therapist (RT) said they were familiar with this resident . They said in the past the resident had been assessed by the MediGas Territory Manager and they had recommended the physician order a specific level of oxygen therapy. The RT said their office had not received a referral for this resident for a specific date. They said they found a fax referral form on the bulletin board in the home which had a specific date and they had no record of having received this fax in the MediGas office.

During an interview the Director of Care (DOC) and Assistant Director of Care (ADOC) said they had not been familiar with this resident as this resident had passed away before they were working in the home. Inspector #630 reviewed the documentation for the resident with the DOC and ADOC and they acknowledged that there was no physician order apart from the medical directive. They acknowledged that the physician's order with a specific date, related to oxygen therapy and a referral to RT for assessment had not been processed at the time the order had been written. They acknowledged that plan of care for staff did not

provide clear direction regarding the resident's oxygen therapy and did not identify the goal of the therapy.

C) During the inspection, Inspector #630 observed another identified resident on multiple occasions with oxygen therapy in place. During one of the observations the resident was observed connected to a portable oxygen tank that was empty.

During an interview a staff member told Inspector #630 that they would know what care a resident required for oxygen therapy by looking at what they had in place and from the nurse telling them. They said sometimes oxygen therapy was included in a resident's plan of care. When asked how they would know what level an oxygen tank was to be set at, the staff member said that they would look at what it was set at and could check with the nurse if they needed to make sure. What asked what their role as a Personal Support Worker (PSW) was in providing oxygen therapy care to the residents, they said they were responsible to make sure the portable oxygen tanks were full and for switching the residents from the one in their room to the portable one or back when taking them out of their room. The staff member said they thought the resident required a specific type of oxygen therapy and this had been in place for a specific period of time.

During an interview another registered nursing staff member said they were familiar with this resident and they thought the oxygen had been started for a specific reason. The staff member said they thought the resident had been assessed by the RT on a specific date and there were specific recommendations. The staff member and Inspector #630 reviewed the physician orders for this resident and the staff member said it looked like the only order for oxygen was the medical directive for use as needed for 72 hours for shortness of breath. The staff member said the resident had been wearing the oxygen at all times and PSW and registered nursing staff were all responsible for ensuring the oxygen therapy was in place. When asked how staff would know what oxygen therapy this resident required, the staff member said the PSWs would ask the registered staff and that they themselves knew from being aware of past needs and the assessment that had been done.

During an interview the Respiratory Therapist (RT) said they were familiar with this resident and the last time this resident had been assessed was a specific date. The RT said that the resident should have had a doctor's order for oxygen therapy that was separate from the medical directive as the medical directive order did not apply in this situation.

The clinical record for this resident showed they had been receiving oxygen therapy in the home. The record included a written order from the physician dated the day after Inspector #630 had interviewed the RT, and there was no order in place prior to that apart from an "as needed" (PRN) Medical Directive. There was no documentation of oxygen care provided to the resident for a specific time frame within the eMAR.

During an interview the Director of Care (DOC) and Assistant Director of Care (ADOC) said they had not yet become familiar with this resident. Inspector #630 reviewed the documentation for this resident with the DOC and ADOC and they acknowledged that there was no physician order apart from the medical directive until a specific date. They acknowledged that the plan of care for staff did not provide clear direction regarding the resident's oxygen therapy and did not identify the goal of the therapy. They said that the plan of care looked like oxygen had been added as an intervention on a specific date, and it would suggest the resident may have been on oxygen since that time but they were not certain. They acknowledged that this resident's oxygen saturation levels had not been documented since a specific date, and when asked how often the staff would be expected to check they said the resident seemed stable from the documentation so there was nothing specific. They acknowledged there was no "oxygen in use" sign on the resident's door at the time of the inspection and said it would be expected to be there. They said that it would also be expected that if the resident was connected to a portable tank that the portable tank would have oxygen in it.

Based on these interviews and record review the licensee has failed to ensure that the written plan of care for three identified residents included their oxygen therapy. The documentation and staff interviews suggested that each of these residents required oxygen therapy for different reasons and the staff had been providing various levels of oxygen therapy to the residents without a physician's order, without goals for care and without a plan of care that provided clear direction for the PSW and registered nursing staff. (630) [s. 6. (1)]

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

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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy and protocol, the policy and protocol was complied with.

In accordance with O. Reg. 79/10, s. 114 (2) the licensee was required to ensure that written policies and protocols are developed for the medication management system to ensure the accurate administration of all drugs used in the home.

In accordance with O. Reg. 79/10, s. 4. for the purposes of the Act and this Regulation, "drug" means a substance or a preparation containing a substance referred to in clauses (a) through (d) of the definition of "drug" in subsection 1 (1) of the Drug and Pharmacies Regulation Act, including a substance that would be excluded from that definition by virtue of clauses (f) to (i) of that definition, but does not include a substance referred to in clause (e) of that definition.

In accordance with Drug and Pharmacies Regulation Act, "drug" means any substance or preparation containing any substance, (a) manufactured, sold or represented for use in (i) the diagnosis, treatment, mitigation or prevention of a disease, disorder, abnormal physical or mental state or the symptoms thereof, in humans, animals or fowl, or (ii) restoring, correcting or modifying functions in humans, animals or fowl.

Also in accordance with O. Reg. 79/10, s. 30 (2) the licensee was required to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The licensee was required to ensure that staff in the home complied with the medication management program and the Nursing and Personal Support Services policies and procedures that were in place to reduce risk related to oxygen therapy.

Specifically, staff did not comply with the MediGas Resource Guide for Long Term Care and Retirement Homes i) "Oxygen Therapy" protocol and ii) "Home Procedure" which were both part of the licensee's medication management program and the Nursing and Personal Support Services.

On a specific date the Executive Director (ED) was asked by Inspector #630 if they had any policies in the home to provide direction for staff regarding oxygen therapy for residents. The ED said that there were Caressant Care policies with the fire safety and health and safety programs in the home but no home specific policies for resident oxygen related care. The ED said the home's service provider was MediGas and they had provided the home with a "Resource Guide for Long-Term Care and Retirement Homes" which was available on each of the units to provide guidance for staff regarding procedures for oxygen therapy in the home.

The MediGas "Oxygen Therapy" protocol included "a physician or nurse practitioner must write a prescription for oxygen therapy. The prescription will indicate how much oxygen the resident needs per minute and how often supplemental oxygen will be required."

The MediGas "Home Procedure" included:

- "Standby concentrators are for immediate use when a resident has an urgent need for oxygen. Medigas is required to be called in order for the resident to be assessed for the optimal modality for mobility, titrated for the oxygen flow rate and to determine if the blood oxygen levels meet the provincial funding criteria."
- "Upon physician's order the home's staff will install the concentrator in the resident's room and explain to the resident the need for oxygen."
- "Adjust the flow rate to prescribed level."
- "Place Oxygen in use sign on the outside of the door to the resident's room."
- "Call Medigas to provide further assessment, equipment instructions and clinical follow-up."
- "The home's staff will follow the home's policies and procedures regarding resident observations and documentation."

A) The home submitted a CIS report to the MOHLTC on a specific date. This report stated that an identified resident had a fall and they were found without their oxygen therapy in place.

The clinical record for this identified resident showed the resident had been using oxygen therapy after their admission to the home on a specific date. The record did not include a documented assessment by a Respiratory Therapist after their admission to the home regarding oxygen therapy, a physician's order for oxygen, the documentation of oxygen care provided in the home within the electronic Medication Administration Record (eMAR) or consistently in the progress notes or regular monitoring of the resident's oxygen saturation levels.

During an interview with an identified registered staff member they told Inspector #630 that if a resident was on oxygen therapy prior to admission most of the time there should be an order for oxygen and the nurses would assess vitals for the first three days. The staff member said they could apply oxygen therapy to a resident as a nursing measure and there should be a physician order but sometimes this had been forgotten at admission. The staff member said that automatically they would keep the resident on the oxygen at the level they were admitted on. When asked how often residents' oxygen saturation levels were to be checked if they were on oxygen therapy, the staff member said that there was not a standard frequency it was just common sense. The staff member said that in the home the Personal Support Workers (PSWs) were allowed to put the oxygen on and could get the tanks and they felt the PSWs lacked knowledge about this therapy. The staff member said they had been familiar with this identified resident and staff had provided oxygen therapy to the resident. The staff member said

based on the location of the resident's room it was hard to monitor the resident. The staff member said the resident did not have their oxygen on at the time of the CI that had been reported to the MOHLTC.

During an interview another registered nursing staff member told Inspector #630 that they could initiate oxygen therapy for residents based on the medical directive for oxygen use and then they would notify the physician. The staff member said that if a resident required oxygen on an ongoing basis they would need to follow an order from the physician. The staff member said it was the expectation in the home that oxygen therapy would be included in the plan of care. The staff member said that the frequency of checking a resident's oxygen saturation levels would depend on clinical signs such as confusion. The staff member said they were familiar with this resident and this resident had required a specific oxygen therapy.

During an interview a Respiratory Therapist (RT) said that Caressant Care Woodstock had a contract with their company to provide oxygen equipment and for the RT to do assessments of the residents' oxygen therapy for the funding. The RT said that the only way they would know that a resident had been admitted to the home on oxygen therapy was if the home faxed or telephoned them a referral. The RT said it was required that all residents admitted to the home on oxygen be referred to MediGas for an assessment of their oxygen therapy requirements. The RT said they had not received a referral from the home regarding this resident and they had not been assessed by the RT after admission regarding their oxygen therapy requirements. The RT said it was the expectation in the home that oxygen therapy would be included in a resident's physician orders. The RT said that MediGas provided policies and procedures to the home that they were required to follow and this was provided with their contract.

During an interview the Director of Care (DOC) and the Assistant Director of Care (ADOC) said they had both started in their current respective roles less than two weeks ago. When asked if they were familiar with the processes in the home for oxygen therapy, they said it was just what they had covered that day reviewing the policies. They said that the only policies that they could find regarding oxygen therapy were the ones provided by MediGas and staff would be expected to follow those policies. They said that staff would also need to rely on best practice in addition to the MediGas policies related to oxygen therapy. They said it would be expected that oxygen therapy would be included as part of the physician's order, the eMAR or eTAR and the plan of care. They said that the only policies that they

could find regarding oxygen therapy were the ones provided by MediGas and staff would be expected to follow those policies. They said that staff would also need to rely on best practice in addition to the MediGas policies related to oxygen therapy. Inspector #630 reviewed the documentation for this resident with the DOC and ADOC and they acknowledged that there was no physician order, medical directive or plan of care for staff that provided clear direction to staff regarding the resident's oxygen therapy.

B) The home submitted another CIS report to the MOHLTC on a specific date. This report stated that an identified resident had been "oxygen dependent."

The clinical record for this identified resident showed this resident had been using oxygen therapy. The clinical record for this resident included a written order from the physician with a specific date which was not processed until a week after it was written. This order did not include a specific prescribed oxygen level and instead stated that the resident was to be on oxygen to maintain oxygen saturation levels above 92 per cent. There were several documented vital signs for specific dates where the resident's oxygen saturation levels were less than 92 per cent and the actions taken by the staff in the home in response to those levels were not consistently documented. There was also no documentation of the oxygen care provided to the resident for a specific time frame within the eMAR or eTAR.

During an interview an identified registered nursing staff member told Inspector #630 that they were familiar with this resident and they required specific interventions. This staff member and Inspector #630 reviewed the physician's orders for this resident and the staff member acknowledged that there was not an order for oxygen and said that oxygen could be applied as a nursing measure. The staff member said they thought the resident's need for oxygen therapy required more than just the oxygen as a nursing measure.

During an interview the Respiratory Therapist (RT) said they were familiar with this resident. They said in the past the resident had been assessed by the MediGas Territory Manager and they had recommended the physician order a specific level of oxygen therapy.

During an interview the Director of Care (DOC) and Assistant Director of Care (ADOC) said they had not been familiar with this resident as this resident had passed away before they were working in the home. Inspector #630 reviewed the

documentation for the resident with the DOC and ADOC and they acknowledged that there was no physician order apart from the medical directive. They acknowledged that the physician's order with a specific date, related to oxygen therapy and a referral to RT for assessment had not been processed at the time the order had been written.

C) During the inspection, Inspector #630 observed another identified resident on multiple occasions with oxygen therapy in place. During one of the observations the resident was observed connected to a portable oxygen tank that was empty.

During an interview a staff member told Inspector #630 that they would know what care a resident required for oxygen therapy by looking at what they had in place and from the nurse telling them. They said sometimes oxygen therapy was included in a resident's plan of care. When asked how they would know what level an oxygen tank was to be set at, the staff member said that they would look at what it was set at and could check with the nurse if they needed to make sure. What asked what their role as a Personal Support Worker (PSW) was in providing oxygen therapy care to the residents, they said they were responsible to make sure the portable oxygen tanks were full and for switching the residents from the one in their room to the portable one or back when taking them out of their room. The staff member said they thought the resident required a specific type of oxygen therapy and this had been in place for a specific period of time.

During an interview another registered nursing staff member said they were familiar with this resident and they thought the oxygen had been started for a specific reason. The staff member said they thought the resident had been assessed by the RT on a specific date and there were specific recommendations. The staff member and Inspector #630 reviewed the physician orders for this resident and the staff member said it looked like the only order for oxygen was the medical directive for use as needed for 72 hours for shortness of breath. The staff member said the resident had been wearing the oxygen at all times and PSW and registered nursing staff were all responsible for ensuring the oxygen therapy was in place. When asked how staff would know what oxygen therapy this resident required, the staff member said the PSWs would ask the registered staff and that they themselves know from being aware of past needs and the assessment that had been done.

During an interview the Respiratory Therapist (RT) said they were familiar with this resident and the last time this resident had been assessed was a specific

date. The RT said that the resident should have had a doctor's order for oxygen therapy that was separate from the medical directive as the medical directive order did not apply in this situation.

The clinical record for this resident showed they had been receiving oxygen therapy in the home. The record included a written order from the physician dated the day after Inspector #630 had interviewed the RT, and there was no order in place prior to that apart from an "as needed" (PRN) Medical Directive. There was no documentation of oxygen care provided to the resident for a specific time frame within the eMAR.

During an interview the Director of Care (DOC) and Assistant Director of Care (ADOC) said they had not yet become familiar with this resident. Inspector #630 reviewed the documentation for this resident with the DOC and ADOC and they acknowledged that there was no physician order apart from the medical directive until a specific date. They acknowledged that plan of care for staff did not provide clear direction regarding the resident's oxygen therapy and did not identify the goal of the therapy. They said that the plan of care looked like oxygen had been added as an intervention on a specific date, and it would suggest the resident may have been on oxygen since that time but they were not certain. They acknowledged that this resident's oxygen saturation levels had not been documented since a specific date, and when asked how often the staff would be expected to check they said the resident seemed stable from the documentation so there was nothing specific. They acknowledged there was no "oxygen in use" sign on the resident's door at the time of the inspection and said it would be expected to be there. They said that it would also be expected that if the resident was connected to a portable tank that the portable tank would have oxygen in it.

Based on these interviews, observations and record review the licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy and protocol, the policy and protocol was complied with regarding oxygen therapy. (630) [s. 8. (1) (b)]

2. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy and procedure, the policy and procedure was complied with related to falls prevention and management.

In accordance with Ontario Regulation 79/10 s. 48 (1) 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury and also in accordance with Ontario Regulation 79/10 s. 30 (1)1, the licensee was required to ensure that staff in the home complied with the falls prevention and management program policies, procedures and protocols that were in place to reduce risk.

Specifically, staff did not comply with the licensee's i) "Safety Plan – Resident" policy and procedure with effective date September 2013 and ii) "CODE CARE: Come, Assess, React, Evaluate" policy and procedure with effective date May 2019, which were both part of the licensee's falls prevention and management program.

The home's "Safety Plan – Resident" policy and procedure included the following procedures under the title "Post Fall Management:"
- "Upon discovering a fall Code Care is called (see policy and procedure – Code Care)."
- "The interdisciplinary team will: c) complete an internal incident report, Post Fall Investigation and detailed progress note; e) Review Safety Plan interventions and modify plan of care as indicated."

The home's "CODE CARE: Come, Assess, React, Evaluate" policy and procedure included the following:
- "Policy: When a resident has a fall a CODE CARE will be paged by the staff member discovering the incident. All staff from that care area are required to respond immediately."
- "Procedure: 1. When a staff member discovers a resident on the floor he/she will immediately go to the nearest phone and page 'Code Care room xx'; 2. Registered staff, PT, PT aide, PSW, NRC and housekeeping from that care area will immediately respond to the location; 3. The staff member who paged the code will bring the resident's Safety Plan Intervention sheet from the paper chart AND a blank post fall investigation form. The person will be the "recorder; 7. Safety Plan Intervention sheet is to be reviewed and updated during the huddle. Review what strategies have been tried, what other interventions doe the group think could be implemented to prevent falls; 10. Upon completion of the huddle the registered staff page "CODE CARE ALL CLEAR" will take the documentation, review and complete as necessary. Using this information the registered staff will completed the required incident reports, update the care plan and communicate results with appropriate managers, oncoming staff etc."

A) The home submitted a CIS report to the MOHLTC on a specific date which was related to an identified resident's fall.

The clinical record for this resident included documentation of the fall by the registered nursing staff member who had been notified of the fall.

During an interview an identified registered nursing staff member told Inspector #630 that they were familiar with the falls prevention and management program in the home and had received education regarding the policies and procedures. The staff member said that when a resident had fallen then code care would be called and the registered nursing staff was expected to respond and assess the resident. The staff member said they had been familiar with this identified resident and they had been working on during the shift when the resident fell. The staff member said they were notified of the fall by another staff member but could not recall when they had been notified. When asked if they were able to respond right away, the staff member said that they had sent down another staff member before they responded.

During an interview with another identified staff member they said they were familiar with the falls prevention and management program in the home and when a resident had a fall they were expected to respond and to do a post fall assessment. They said that if a code care was called while they were working in the home they would attend to assist, to assess for injury and to make recommendations. They said they would document a progress note right after the fall. The staff member said they were familiar with this identified resident and been working in the home on the date the resident fell. They said a staff member had called the code care. They said they responded to the code care by going to the desk and then they had been told by the registered nursing staff member to go and see the resident. They said when they arrived at the room there were two other staff present who said they were waiting for the nurse. They said it was about five minutes before the registered nursing staff member arrived to the resident's room.

During an interview with another staff member they said they were familiar with the home's fall prevention and management program and had received education. They said that if a resident has fallen the PSWs were expected to ring for assistance and if the resident was safe then go and find someone to help. The staff member said they were familiar with this resident and they had been working

on the shift during which the resident fell. This staff member said they had responded to the fall as they heard a callbell ringing. The staff member said that they went down to get the registered nursing staff member two times and that they had yelled that it was really an emergency. The staff member said it seemed like a long time before the registered nursing staff responded.

During an interview with another identified staff member they said when a resident had fallen in the home they were expected to respond to the code care. They said they had been familiar with this identified resident and they had responded to their fall on a specific date. They said when they responded there were two other staff in the resident's room and this was before code care had been called. They said another staff member responded before the registered nursing staff member and that one of the other staff members had to walk all the way down to the desk twice before the registered staff member came to the resident's room.

During an interview with another identified staff member they told Inspector #630 that they were familiar with the home's falls prevention and management program and had received education prior to working in the home. When asked what they were expected to do if a resident has fallen, they said that they were to call a code care go back to resident and put a pillow get the lift to get them up after the staff have responded. They said they were familiar with this identified resident and had been working on the day when the resident had fallen. The staff member said they did not know how long the callbell had been ringing prior to them responding as they had been in a room with another. The staff member said they thought it took the registered nursing staff member 10 to 15 minutes before they responded as they thought the nurse misunderstood which resident needed help.

During an interview the Executive Director (ED) said they were new to the position at the time of this incident. ED said that they had not personally been involved in investigating or reporting this CI and was therefor relying on the CIS documentation to answer questions about this incident. When asked what the staff member who discovered the fall did in response to the fall, the ED said they called down the hall and the other staff member stayed with the resident. The ED said they did not know if the other staff member was there right away. When asked if they were able to determine how long the resident's bell had been ringing prior to the staff responding, the ED said no as they did not have the type of system to be able to tell that information. When asked how the registered staff were notified of the fall, the ED said they thought that one of the staff members

had called down the hall. When asked how long it was between when the staff member notified the registered nursing staff of the fall and when they responded by going to the resident's room, the ED said they did not know. When asked if anyone brought forward a concern that another staff member was sent to respond prior to the registered nursing staff responding, the ED said they had not heard of that concern. The ED said that they had met with the identified registered nursing staff member after the incident regarding their response and were counselled that if they were called down the hall to assist then they needed to go. The ED said based on the home's Code Care policy staff were expected to go to the phone and call code care and staff were expected to respond to the fall immediately.

B) The clinical record for an identified resident showed the resident had nine documented falls during a specific time frame. Each documented fall was related to the a specific action taken by the resident without staff assistance. The written plan of care for the resident included specific interventions which were documented as having been updated on a specific date.

During an interview the Resident Assessment Instrument (RAI) Coordinator said they were familiar with this identified resident and they were considered to be at high risk for falls and continued to fall. They said this resident required specific interventions for mobility and falls prevention. The RAI Coordinator and Inspector #630 reviewed the post fall assessments that had been documented for this resident for a specific time frame, and it was identified that this resident had a nine documented falls. RAI Coordinator said this resident had a "Safety Plan Intervention" form that was part of their clinical record and the last time this form was updated was in May 2019. The RAI Coordinator said it was the expectation in the home according to the policy that the resident's fall prevention interventions would be reviewed and updated after each fall and that this was documented on the "Safety Plan Interventions" form. The RAI Coordinator said the interventions that were in place to minimize the resident's risk for falls were not effective.

During an interview with a Resident Care Coordinator (RCC) they said that they were the lead for the Falls Prevention and Management Program in the home starting when they started in the RCC position in May 2019. The RCC said they were familiar with this resident and this resident was considered to be at risk for falls. The RCC acknowledged that there were interventions included in this resident's plan of care that were not effective interventions for this resident. The RCC said that the main intervention that was used within the home for falls prevention was bed or chair alarms and that the fall prevention and management

committee had started in May 2019 to work on identifying other interventions to implemented for residents in the home to help minimize falls. The RCC said that it was the expectation in the home that the CODE Care policy would be complied with and that included the use of the "Safety Plan Intervention" sheet after each fall to review the strategies that had been tried and identify other interventions that could be implemented to prevent future falls.

C) The home submitted a Critical Incident System (CIS) report regarding a fall which another identified resident sustained on a specific date. This CIS report stated that this resident sustained a specific injury related to the fall.

The clinical record for this resident included a post fall assessment for the fall that had been reported in the CIS report and indicated that the fall was related to a specific type of action taken by the resident. The "Safety Plan Interventions" form for this resident was not completed until 14 days after the fall. This clinical record also showed that the resident had fallen on three other specific dates after the fall reported to the MOHLTC through the CIS. The "Safety Plan Interventions" form had no documentation after these falls. The written plan of care for this resident was not updated after each of these subsequent falls.

During an interview a Resident Assessment Instrument (RAI) Coordinator said they were familiar with this resident and they were considered to be at risk for falls. They said this resident had experience a fall which resulted in a specific type of injury. The RAI Coordinator acknowledged that based on the documentation in Risk Management this resident had experience three other falls. The RAI Coordinator and Inspector #630 reviewed the post fall assessments that had been documented for this resident during a specific time frame, and it was identified that there was a "Safety Plan Intervention" form that was part of their clinical record and the last time this form was not updated after each fall. The RAI Coordinator said it was the expectation in the home according to the policy that the resident's fall prevention interventions would be reviewed and updated after each fall and that this was to be documented on the "Safety Plan Interventions" form.

D) During the inspection, Inspector #630 observed another identified resident using a specific mobility device on multiple occasions.

The clinical record for this identified resident documented the resident had seven documented falls during a specific time frame. The post-fall assessment for one

of the falls showed the resident had sustained a specific type of injury. The "Safety Plan Interventions" form in this resident's record was last updated in 2016. The written plan of care for this resident had not been updated regarding mobility interventions or falls prevention interventions to reflect the interventions that were in place.

During an interview an identified registered nursing staff member said this resident had sustained two falls on a specific date. When asked what interventions were in place to help minimize their risk for falls, the staff member described why the resident was at risk for falls and did not describe interventions that were in place. The staff member said that the staff were using a specific mobility device at times for the resident at the request of the family.

During an interview with another staff member they said they were familiar with this resident and they were considered to be at risk for falls. When asked what intervention were in place to help minimize the resident's risk of falls, the staff member said that the staff had started using a specific mobility device with the resident as well as encouraged rest. The staff member said they could not think of any other interventions that were in place to help minimize resident's risk for falls.

During an interview with a Resident Assessment Instrument (RAI) Coordinator they said they were familiar with this identified resident and they were considered to be at risk for falls and continued to fall. The RAI Coordinator said this resident had a "Safety Plan Intervention" form that was part of their clinical record and the last time this form was updated was in 2016. The RAI Coordinator said the interventions that were in place to minimize the resident's risk for falls were not effective. The RAI Coordinator said that this resident had been using a specific mobility device at times and acknowledged that this had not been included in the plan of care as an intervention.

During an interview the Resident Care Coordinator (RCC) said they were familiar with this resident and this resident was considered to be at high risk for falls. When asked if the interventions that were in place effectively minimized the resident's risk of falls, the RCC said that staff should be looking at the interventions and the plan of care after each fall and they were not sure what alternative interventions had been tried or implemented for the resident. The RCC said they thought after one of the resident's falls the family had wanted the resident to use the specific mobility device. The RCC said that intervention

should be included in the plan of care if it was being used for the resident. The RCC said it was the expectation that the Safety Plan Intervention sheet would be completed after each fall and acknowledged that these were not consistently being completed by the staff in the home. The RCC said they were working through the policy and identifying that there was so much involved in the post fall documentation and assessment and it took staff almost an hour to complete so looking at the paper work and trying to get it changed to an electronic format for all the pieces. They should be looking at the interventions that were in place as part of the post fall assessment and looking at what interventions had been tried and what ones should be trialled, and staff had not consistently been doing that. (630) [s. 8. (1) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 002

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.

This inspection was completed related to a Critical Incident System (CIS) report that was submitted by the home to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date. Review of the CIS report showed an identified resident sustained a specific type of injury during care and the home had initiated an internal investigation.

Documented evidence showed that an identified staff member had completed a written letter regarding the incident which described the specific injury.

The plan of care for this identified resident included specific interventions for mobility and positioning.

Observations by Inspector #610 during the inspection found the resident did not have the bed mobility device in place as was specified in their plan of care.

During an interview with an identified staff member they said this resident should have had this device in place and explained to Inspector #610 how the device worked for positioning and bed mobility.

Further review of documented evidence showed that a written letter had been completed by another identified staff member regarding the positioning care that had been provided to this resident on that specific date.

An email to the former Director of Care (DOC) from the MIP Senior Account Manager stated this specific device was to be used with two staff.

During an interview the Executive Director (ED) said that the home's expectation was that this bed mobility device would only be used by two staff when providing resident care. (610) [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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of every abuse or neglect investigation were reported to the Director.

A) This inspection was completed related to a Critical Incident System (CIS) report submitted by the home to the Ministry of Health and Long-Term Care (MOHLTC) related to an injury sustained by an identified resident during care. The CIS report was amended on a specific date by former DOC, however, the report did not contain the results of the home's investigation.

The home's investigation documentation showed that an identified staff member had completed a written letter regarding the incident. It also included an email to the former Director of Care (DOC) from MIP Senior Account Manager regarding the safe use of a specific bed mobility device.

During an interview, the Executive Director (ED) said that the former DOC should have updated the Director with the most up to date internal investigation notes. (610)

B) This inspection was completed related to another CIS report submitted to the MOHLTC regarding alleged misappropriation of a resident's money. The former

DOC amended the CIS report, but did not include the results of the internal investigation by including that the money was not recovered or the results of the surveillance.

An internal investigation report showed that the home initiated an internal investigation and had hired a security company for surveillance.

During an interview the Security Operational Manger said that they were in the home for about ten days twenty-four hours a day. They said they had an officer in the home dressed in uniform as a visual deterrent. However they said they were not completing surveillance while in the home, and there was no evidence that theft was occurring during that time frame.

During an interview the Caressant Care Vice President of Operations said that the security company did come to the home but the findings were inconclusive and the money was not found. However since the incidents of theft in the home, cameras had been installed in seven various locations around the home to also act as a deterrent for staff, residents, and visitors in the home.

The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director. (610) [s. 23. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that, in regards to the annual evaluation of the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents: the results of the analysis of every incident of abuse or neglect were considered in the evaluation; the changes and improvements identified within the review were promptly implemented; and the written record of the evaluation included the date that the changes and improvements were implemented.

When asked to provide the documented record of the last annual review of the home's prevention of abuse and neglect program, the management in home provided Inspector #610 with a form titled "Quality Program Evaluation Abuse Prevention" dated October 15, 2018. This record documented that the home had 29 Critical Incidents (CI) submitted for 2018. The documentation did not show that analysis of the incidents had been part of the annual evaluation. The record included a section titled "list actions/areas for improvement" which stated "immediate reporting; documentation of the incident; streamline and clarify reporting process for allegations of abuse to ensure immediate after-hours

reporting. 25% of reports late and no after hours called. 2018 [year to date] YTD 48% late or no after hours called. Decision tool provided by MOHLTC circulated to nursing managers, needs to be followed 100 per cent." The review did not include documented evidence that the improvements were promptly implemented and did not document the date that the improvements were implemented. The form showed that an "action plan" had been developed and that the evaluation had been discussed by the "management team" on October 15, 2018. The form did not document which members of the management team had been involved in this discussion. The form stated that the results were taken to the "CQI Committee" December 2018.

The management in the home provided Inspector #610 with the minutes of the home's CQI team meeting held on December 21, 2018. These minutes documented "Abuse Program evaluation, discussed results of the evaluation, reviewed trends, list of action and goal." There was no further documented evidence that the results of the analysis of every incident of abuse or neglect were considered in the evaluation or that the changes and improvements identified within the review were promptly implemented.

During an interview with the Caressant Care Vice President of Operations they acknowledged that the home's annual evaluation of the abuse and neglect policy did not include the date that the changes and improvements were implemented.

The licensee has failed to ensure that the home's annual evaluation of the prevention of abuse and neglect policy required under O Reg 79/10 s. 99 (1) was completed in accordance with the legislative requirements. Specifically, the documented record of the evaluation did not show that an analysis of every incident of abuse or neglect was considered in the evaluation; that the changes and improvements identified within the review were promptly implemented; or included the date that the changes and improvements were implemented. [s. 99. (d)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 18th day of October, 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 AMIE GIBBS-WARD (630) - (A1)
Inspection No. / No de l'inspection :	2019_722630_0017 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	006306-19, 007718-19, 008413-19, 010025-19, 012449-19, 012912-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 18, 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 Woodstock Nursing Home 81 Fyfe Avenue, WOODSTOCK, ON, N4S-8Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carol Bradley

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:

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)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with s. 6. (1) of the LTCHA.

Specifically the licensee must:

a) Ensure that there is a written plan of care for an identified resident, and any other resident who receives oxygen therapy in the home, that sets out: (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident related to their oxygen therapy. The written plan of care must include a physician's order for the oxygen therapy.

b) Ensure that when a resident is newly admitted to the home who requires oxygen therapy, there is a written plan of care which is based on an interdisciplinary assessment. This plan of care must include: (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident related to their oxygen therapy. The written plan of care must include a physician's order for the oxygen therapy.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written plan of care for each

resident that set out: (a) the planned care for the resident; (b) the goals the care was intended to achieve; and (c) clear directions to staff and others who provided direct care to the residents related to oxygen therapy.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date. This report stated that an identified resident had a fall and they were found without their oxygen therapy in place.

The clinical record for this identified resident showed the resident had been using oxygen therapy after their admission to the home on a specific date. The record did not include a documented assessment by a Respiratory Therapist after their admission to the home regarding oxygen therapy, a physician's order for oxygen, the documentation of oxygen care provided in the home within the electronic Medication Administration Record (eMAR) or consistently in the progress notes or regular monitoring of the resident's oxygen saturation levels.

During an interview with an identified registered staff member they told Inspector #630 that if a resident was on oxygen therapy prior to admission most of the time there should be an order for oxygen and the nurses would assess vitals for the first three days. The staff member said they could apply oxygen therapy to a resident as a nursing measure and there should be a physician order but sometimes this had been forgotten at admission. The staff member said that automatically they would keep the resident on the oxygen at the level they were admitted on. When asked how often residents' oxygen saturation levels were to be checked if they were on oxygen therapy, the staff member said that there was not a standard frequency it was just common sense. The staff member said that in the home the Personal Support Workers (PSWs) were allowed to put the oxygen on and could get the tanks and they felt the PSWs lacked knowledge about this therapy. The staff member said they had been familiar with this identified resident and staff had provided oxygen therapy to the resident. The staff member said based on the location of the resident's room it was hard to monitor the resident. The staff member said the resident did not have their oxygen on at the time of the CI that had been reported to the MOHLTC.

During interview with another staff member they said they were familiar with this resident and this resident required oxygen therapy and required specific interventions

from staff.

During an interview another registered nursing staff member told Inspector #630 that they could initiate oxygen therapy for residents based on the medical directive for oxygen use and then they would notify the physician. The staff member said that if a resident required oxygen on an ongoing basis they would need to follow an order from the physician. The staff member said it was the expectation in the home that oxygen therapy would be included in the plan of care. The staff member said that the frequency of checking a resident's oxygen saturation levels would depend on clinical signs such as confusion. The staff member said they were familiar with this resident and this resident had required a specific oxygen therapy.

During an interview a Respiratory Therapist (RT) said that Caressant Care Woodstock had a contract with their company to provide oxygen equipment and for the RT to do assessments of the residents' oxygen therapy for the funding. The RT said that the only way they would know that a resident had been admitted to the home on oxygen therapy was if the home faxed or telephoned them a referral. The RT said they had not received a referral from the home regarding this resident and they had not been assessed by the RT after admission regarding their oxygen therapy requirements. The RT said it was the expectation in the home that oxygen therapy would be included in a resident's physician orders.

During an interview the Director of Care (DOC) and the Assistant Director of Care (ADOC) said they had both started in their current respective roles less than two weeks ago. When asked if they were familiar with the processes in the home for oxygen therapy, they said it was just what they had covered that day reviewing the policies. They said it would be expected that oxygen therapy would be included as part of the physician's order, the eMAR or eTAR and the plan of care. Inspector #630 reviewed the documentation for this resident with the DOC and ADOC and they acknowledged that there was no physician order, medical directive or plan of care for staff that provided clear direction to staff regarding the resident's oxygen therapy. When asked how often staff would be expected to have checked the resident's oxygen saturation levels, they said that staff would be expected to do it if there were signs of symptoms of desaturation and acknowledged this was not part of the plan of care. They also acknowledged that the plan of care did not provide clear direction regarding the desired oxygen saturation levels for this resident or other goals of oxygen therapy for this resident.

B) The home submitted another CIS report to the MOHLTC on a specific date. This report stated that an identified resident had been "oxygen dependent."

The clinical record for this identified resident showed this resident had been using oxygen therapy. The clinical record for this resident included a written order from the physician with a specific date which was not process until a week after it was written. This order did not include a specific prescribed oxygen level and instead stated that the resident was to be on oxygen to maintain oxygen saturation levels above 92 per cent. There were several documented vital signs for specific dates where the resident's oxygen saturation levels were less than 92 per cent and the actions taken by the staff in the home in response to those levels were not consistently documented. There was also no documentation of the oxygen care provided to the resident for a specific time frame within the eMAR or eTAR.

During an interview an identified registered nursing staff member told Inspector #630 that they were familiar with this resident and they required specific interventions. This staff member said they thought the resident needed a reassessment by the RT and had requested a referral from the physician. The staff member said they did not know what happened with the RT referral. This staff member and Inspector #630 reviewed the physician's orders for this resident and the staff member acknowledged that there was no order for oxygen and said that oxygen could be applied as a nursing measure. The staff member said they thought the resident's need for oxygen therapy required more than just the oxygen as a nursing measure.

During an interview the Respiratory Therapist (RT) said they were familiar with this resident . They said in the past the resident had been assessed by the MediGas Territory Manager and they had recommended the physician order a specific level of oxygen therapy. The RT said their office had not received a referral for this resident for a specific date. They said they found a fax referral form on the bulletin board in the home which had a specific date and they had no record of having received this fax in the MediGas office.

During an interview the Director of Care (DOC) and Assistant Director of Care (ADOC) said they had not been familiar with this resident as this resident had passed away before they were working in the home. Inspector #630 reviewed the documentation for the resident with the DOC and ADOC and they acknowledged that

there was no physician order apart from the medical directive. They acknowledged that the physician's order with a specific date, related to oxygen therapy and a referral to RT for assessment had not been processed at the time the order had been written. They acknowledged that plan of care for staff did not provide clear direction regarding the resident's oxygen therapy and did not identify the goal of the therapy.

C) During the inspection, Inspector #630 observed another identified resident on multiple occasions with oxygen therapy in place. During one of the observations the resident was observed connected to a portable oxygen tank that was empty.

During an interview a staff member told Inspector #630 that they would know what care a resident required for oxygen therapy by looking at what they had in place and from the nurse telling them. They said sometimes oxygen therapy was included in a resident's plan of care. When asked how they would know what level an oxygen tank was to be set at, the staff member said that they would look at what it was set at and could check with the nurse if they needed to make sure. What asked what their role as a Personal Support Worker (PSW) was in providing oxygen therapy care to the residents, they said they were responsible to make sure the portable oxygen tanks were full and for switching the residents from the one in their room to the portable one or back when taking them out of their room. The staff member said they thought the resident required a specific type of oxygen therapy and this had been in place for a specific period of time.

During an interview another registered nursing staff member said they were familiar with this resident and they thought the oxygen had been started for a specific reason. The staff member said they thought the resident had been assessed by the RT on a specific date and there were specific recommendations. The staff member and Inspector #630 reviewed the physician orders for this resident and the staff member said it looked like the only order for oxygen was the medical directive for use as needed for 72 hours for shortness of breath. The staff member said the resident had been wearing the oxygen at all times and PSW and registered nursing staff were all responsible for ensuring the oxygen therapy was in place. When asked how staff would know what oxygen therapy this resident required, the staff member said the PSWs would ask the registered staff and that they themselves knew from being aware of past needs and the assessment that had been done.

During an interview the Respiratory Therapist (RT) said they were familiar with this

resident and the last time this resident had been assessed was a specific date. The RT said that the resident should have had a doctor's order for oxygen therapy that was separate from the medical directive as the medical directive order did not apply in this situation.

The clinical record for this resident showed they had been receiving oxygen therapy in the home. The record included a written order from the physician dated the day after Inspector #630 had interviewed the RT, and there was no order in place prior to that apart from an "as needed" (PRN) Medical Directive. There was no documentation of oxygen care provided to the resident for a specific time frame within the eMAR.

During an interview the Director of Care (DOC) and Assistant Director of Care (ADOC) said they had not yet become familiar with this resident. Inspector #630 reviewed the documentation for this resident with the DOC and ADOC and they acknowledged that there was no physician order apart from the medical directive until a specific date. They acknowledged that the plan of care for staff did not provide clear direction regarding the resident's oxygen therapy and did not identify the goal of the therapy. They said that the plan of care looked like oxygen had been added as an intervention on a specific date, and it would suggest the resident may have been on oxygen since that time but they were not certain. They acknowledged that this resident's oxygen saturation levels had not been documented since a specific date, and when asked how often the staff would be expected to check they said the resident seemed stable from the documentation so there was nothing specific. They acknowledged there was no "oxygen in use" sign on the resident's door at the time of the inspection and said it would be expected to be there. They said that it would also be expected that if the resident was connected to a portable tank that the portable tank would have oxygen in it.

Based on these interviews and record review the licensee has failed to ensure that the written plan of care for three identified residents included their oxygen therapy. The documentation and staff interviews suggested that each of these residents required oxygen therapy for different reasons and the staff had been providing various levels of oxygen therapy to the residents without a physician's order, without goals for care and without a plan of care that provided clear direction for the PSW and registered nursing staff. (630) [s. 6. (1)]

The severity of this issue was determined to be a level three as there was potential for actual risk. The scope of the issue was a level three as it related to three out of three residents inspected. The home had a level 3 history as they had previous non-compliance to the same sub-section of the legislation that included:

- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued April 16, 2019 (2019_722630_0007);
- WN issued October 23, 2018 (2018_722630_0019);
- WN and VPC issued October 20, 2016 (2016_326569_0021). (630)

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

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 O. Reg. 79/10, s 8. (1).

Specifically the licensee must:

a) Ensure the home's oxygen therapy policies, procedures and protocols are reviewed and revised to ensure they provide clear home-specific directions for staff regarding the provision of oxygen therapy to residents in the home. This review must:
i) ensure that any home specific policy or procedure referred to within an oxygen therapy related policy or procedure has also been developed and implemented;
ii) ensure the policy and procedure provides clear direction for staff regarding the procedures to follow when a resident is admitted to the home requiring oxygen therapy,
iii) ensure the policy provides direction for Personal Support Workers (PSWs) and registered nursing staff regarding their roles and responsibilities in providing oxygen therapy;
iv) include input from the Respiratory Therapist (RT) who provides contracted service to the home;
v) include at least one Personal Support Worker (PSW), one Registered Practical Nurse (RPN) and one Registered Nurse (RN) working in the home

to help determine if the policies and procedures provide clear direction for staff;
vi) include a documented record of the review and the revisions made, including the name of the staff involved and the date they were involved.

b) Ensure the Director of Care (DOC), Assistant Director of Care (ADOC), Resident Care Cooridnators (RCCs), all RAI-Coordinators, all RPNs, RNs including agency staff and all PSWs are trained on the revised oxygen therapy policies. The home must keep a documented record of the education provided including: the percentage of staff who completed the education by the compliance due date; the staff who provided the education; the dates when it was provided; and the materials that were covered during the education.

c) Ensure the revised oxygen therapy policies and procedures are fully implemented for an identified resident, and any other resident in the home who is administered oxygen therapy.

Grounds / Motifs :

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

In accordance with O. Reg. 79/10, s. 114 (2) the licensee was required to ensure that written policies and protocols are developed for the medication management system to ensure the accurate administration of all drugs used in the home.

In accordance with O. Reg. 79/10, s. 4. for the purposes of the Act and this Regulation, "drug" means a substance or a preparation containing a substance referred to in clauses (a) through (d) of the definition of "drug" in subsection 1 (1) of the Drug and Pharmacies Regulation Act, including a substance that would be excluded from that definition by virtue of clauses (f) to (i) of that definition, but does not include a substance referred to in clause (e) of that definition.

In accordance with Drug and Pharmacies Regulation Act, "drug" means any substance or preparation containing any substance, (a) manufactured, sold or represented for use in (i) the diagnosis, treatment, mitigation or prevention of a

disease, disorder, abnormal physical or mental state or the symptoms thereof, in humans, animals or fowl, or (ii) restoring, correcting or modifying functions in humans, animals or fowl.

Also in accordance with O. Reg. 79/10, s. 30 (2) the licensee was required to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The licensee was required to ensure that staff in the home complied with the medication management program and the Nursing and Personal Support Services policies and procedures that were in place to reduce risk related to oxygen therapy.

Specifically, staff did not comply with the MediGas Resource Guide for Long Term Care and Retirement Homes i) "Oxygen Therapy" protocol and ii) "Home Procedure" which were both part of the licensee's medication management program and the Nursing and Personal Support Services.

On a specific date the Executive Director (ED) was asked by Inspector #630 if they had any policies in the home to provide direction for staff regarding oxygen therapy for residents. The ED said that there were Caressant Care policies with the fire safety and health and safety programs in the home but no home specific policies for resident oxygen related care. The ED said the home's service provider was MediGas and they had provided the home with a "Resource Guide for Long-Term Care and Retirement Homes" which was available on each of the units to provide guidance for staff regarding procedures for oxygen therapy in the home.

The MediGas "Oxygen Therapy" protocol included "a physician or nurse practitioner must write a prescription for oxygen therapy. The prescription will indicate how much oxygen the resident needs per minute and how often supplemental oxygen will be required."

The MediGas "Home Procedure" included:
- "Standby concentrators are for immediate use when a resident has an urgent need for oxygen. Medigas is required to be called in order for the resident to be assessed for the optimal modality for mobility, titrated for the oxygen flow rate and to determine if the blood oxygen levels meet the provincial funding criteria."

- "Upon physician's order the home's staff will install the concentrator in the resident's room and explain to the resident the need for oxygen."
- "Adjust the flow rate to prescribed level."
- "Place Oxygen in use sign on the outside of the door to the resident's room."
- "Call Medigas to provide further assessment, equipment instructions and clinical follow-up."
- "The home's staff will follow the home's policies and procedures regarding resident observations and documentation."

A) The home submitted a CIS report to the MOHLTC on a specific date. This report stated that an identified resident had a fall and they were found without their oxygen therapy in place.

The clinical record for this identified resident showed the resident had been using oxygen therapy after their admission to the home on a specific date. The record did not include a documented assessment by a Respiratory Therapist after their admission to the home regarding oxygen therapy, a physician's order for oxygen, the documentation of oxygen care provided in the home within the electronic Medication Administration Record (eMAR) or consistently in the progress notes or regular monitoring of the resident's oxygen saturation levels.

During an interview with an identified registered staff member they told Inspector #630 that if a resident was on oxygen therapy prior to admission most of the time there should be an order for oxygen and the nurses would assess vitals for the first three days. The staff member said they could apply oxygen therapy to a resident as a nursing measure and there should be a physician order but sometimes this had been forgotten at admission. The staff member said that automatically they would keep the resident on the oxygen at the level they were admitted on. When asked how often residents' oxygen saturation levels were to be checked if they were on oxygen therapy, the staff member said that there was not a standard frequency it was just common sense. The staff member said that in the home the Personal Support Workers (PSWs) were allowed to put the oxygen on and could get the tanks and they felt the PSWs lacked knowledge about this therapy. The staff member said they had been familiar with this identified resident and staff had provided oxygen therapy to the resident. The staff member said based on the location of the resident's room it was hard to monitor the resident. The staff member said the resident did not have their oxygen on at the time of the CI that had been reported to

the MOHLTC.

During an interview another registered nursing staff member told Inspector #630 that they could initiate oxygen therapy for residents based on the medical directive for oxygen use and then they would notify the physician. The staff member said that if a resident required oxygen on an ongoing basis they would need to follow an order from the physician. The staff member said it was the expectation in the home that oxygen therapy would be included in the plan of care. The staff member said that the frequency of checking a resident's oxygen saturation levels would depend on clinical signs such as confusion. The staff member said they were familiar with this resident and this resident had required a specific oxygen therapy.

During an interview a Respiratory Therapist (RT) said that Caressant Care Woodstock had a contract with their company to provide oxygen equipment and for the RT to do assessments of the residents' oxygen therapy for the funding. The RT said that the only way they would know that a resident had been admitted to the home on oxygen therapy was if the home faxed or telephoned them a referral. The RT said it was required that all residents admitted to the home on oxygen be referred to MediGas for an assessment of their oxygen therapy requirements. The RT said they had not received a referral from the home regarding this resident and they had not been assessed by the RT after admission regarding their oxygen therapy requirements. The RT said it was the expectation in the home that oxygen therapy would be included in a resident's physician orders. The RT said that MediGas provided policies and procedures to the home that they were required to follow and this was provided with their contract.

During an interview the Director of Care (DOC) and the Assistant Director of Care (ADOC) said they had both started in their current respective roles less than two weeks ago. When asked if they were familiar with the processes in the home for oxygen therapy, they said it was just what they had covered that day reviewing the policies. They said that the only policies that they could find regarding oxygen therapy were the ones provided by MediGas and staff would be expected to follow those policies. They said that staff would also need to rely on best practice in addition to the MediGas policies related to oxygen therapy. They said it would be expected that oxygen therapy would be included as part of the physician's order, the eMAR or eTAR and the plan of care. They said that the only policies that they could find regarding oxygen therapy were the ones provided by MediGas and staff would

be expected to follow those policies. They said that staff would also need to rely on best practice in addition to the MediGas policies related to oxygen therapy. Inspector #630 reviewed the documentation for this resident with the DOC and ADOC and they acknowledged that there was no physician order, medical directive or plan of care for staff that provided clear direction to staff regarding the resident's oxygen therapy.

B) The home submitted another CIS report to the MOHLTC on a specific date. This report stated that an identified resident had been "oxygen dependent."

The clinical record for this identified resident showed this resident had been using oxygen therapy. The clinical record for this resident included a written order from the physician with a specific date which was not processed until a week after it was written. This order did not include a specific prescribed oxygen level and instead stated that the resident was to be on oxygen to maintain oxygen saturation levels above 92 per cent. There were several documented vital signs for specific dates where the resident's oxygen saturation levels were less than 92 per cent and the actions taken by the staff in the home in response to those levels were not consistently documented. There was also no documentation of the oxygen care provided to the resident for a specific time frame within the eMAR or eTAR.

During an interview an identified registered nursing staff member told Inspector #630 that they were familiar with this resident and they required specific interventions. This staff member and Inspector #630 reviewed the physician's orders for this resident and the staff member acknowledged that there was not an order for oxygen and said that oxygen could be applied as a nursing measure. The staff member said they thought the resident's need for oxygen therapy required more than just the oxygen as a nursing measure.

During an interview the Respiratory Therapist (RT) said they were familiar with this resident. They said in the past the resident had been assessed by the MediGas Territory Manager and they had recommended the physician order a specific level of oxygen therapy.

During an interview the Director of Care (DOC) and Assistant Director of Care (ADOC) said they had not been familiar with this resident as this resident had passed away before they were working in the home. Inspector #630 reviewed the documentation for the resident with the DOC and ADOC and they acknowledged that

there was no physician order apart from the medical directive. They acknowledged that the physician's order with a specific date, related to oxygen therapy and a referral to RT for assessment had not been processed at the time the order had been written.

C) During the inspection, Inspector #630 observed another identified resident on multiple occasions with oxygen therapy in place. During one of the observations the resident was observed connected to a portable oxygen tank that was empty.

During an interview a staff member told Inspector #630 that they would know what care a resident required for oxygen therapy by looking at what they had in place and from the nurse telling them. They said sometimes oxygen therapy was included in a resident's plan of care. When asked how they would know what level an oxygen tank was to be set at, the staff member said that they would look at what it was set at and could check with the nurse if they needed to make sure. What asked what their role as a Personal Support Worker (PSW) was in providing oxygen therapy care to the residents, they said they were responsible to make sure the portable oxygen tanks were full and for switching the residents from the one in their room to the portable one or back when taking them out of their room. The staff member said they thought the resident required a specific type of oxygen therapy and this had been in place for a specific period of time.

During an interview another registered nursing staff member said they were familiar with this resident and they thought the oxygen had been started for a specific reason. The staff member said they thought the resident had been assessed by the RT on a specific date and there were specific recommendations. The staff member and Inspector #630 reviewed the physician orders for this resident and the staff member said it looked like the only order for oxygen was the medical directive for use as needed for 72 hours for shortness of breath. The staff member said the resident had been wearing the oxygen at all times and PSW and registered nursing staff were all responsible for ensuring the oxygen therapy was in place. When asked how staff would know what oxygen therapy this resident required, the staff member said the PSWs would ask the registered staff and that they themselves know from being aware of past needs and the assessment that had been done.

During an interview the Respiratory Therapist (RT) said they were familiar with this resident and the last time this resident had been assessed was a specific date. The

RT said that the resident should have had a doctor's order for oxygen therapy that was separate from the medical directive as the medical directive order did not apply in this situation.

The clinical record for this resident showed they had been receiving oxygen therapy in the home. The record included a written order from the physician dated the day after Inspector #630 had interviewed the RT, and there was no order in place prior to that apart from an "as needed" (PRN) Medical Directive. There was no documentation of oxygen care provided to the resident for a specific time frame within the eMAR.

During an interview the Director of Care (DOC) and Assistant Director of Care (ADOC) said they had not yet become familiar with this resident. Inspector #630 reviewed the documentation for this resident with the DOC and ADOC and they acknowledged that there was no physician order apart from the medical directive until a specific date. They acknowledged that plan of care for staff did not provide clear direction regarding the resident's oxygen therapy and did not identify the goal of the therapy. They said that the plan of care looked like oxygen had been added as an intervention on a specific date, and it would suggest the resident may have been on oxygen since that time but they were not certain. They acknowledged that this resident's oxygen saturation levels had not been documented since a specific date, and when asked how often the staff would be expected to check they said the resident seemed stable from the documentation so there was nothing specific. They acknowledged there was no "oxygen in use" sign on the resident's door at the time of the inspection and said it would be expected to be there. They said that it would also be expected that if the resident was connected to a portable tank that the portable tank would have oxygen in it.

Based on these interviews, observations and record review the licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy and protocol, the policy and protocol was complied with regarding oxygen therapy. (630) [s. 8. (1) (b)]

The severity of this issue was determined to be a level three as there was potential for actual risk. The scope of the issue was a level three as it was widespread. The home had a level 3 history as they had previous non-compliance to the same sub-section of the legislation that included:

- Written Notification (WN) and Compliance Order (CO) issued May 7, 2019 (2019_778563_0013) with compliance due date May 31, 2019. The CO was complied July 2019.
- WN and CO issued February 19, 2019 (2019_778563_0006) with compliance due date March 31, 2019 which was closed with link May 7, 2019;
- WN and CO issued October 23, 2018 (2018_722630_0019) with compliance due date June 30, 2019. The CO was complied July 2019;
- WN and CO issued July 16, 2018 (2018_508137_0017) with compliance due date July 31, 2018 which was closed with link October 23, 2019;
- WN and Voluntary Plan of Correction (VPC) issued January 17, 2018 (2018_606563_0001);
- WN, CO and Director's Referral (DR) issued August 24, 2017 (2017_605213_0015) with compliance due date September 8, 2017. This CO was complied October 5, 2017;
- WN and CO issued May 24, 2017 (2016_229213_0039) with compliance due date June 30, 2017 which was closed with link August 23, 2017;
- WN issued October 20, 2016 (2016_326569_0021). (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 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 : 003

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 must be compliant with O. Reg. 79/10, s 8. (1).

Specifically the licensee must:

a) Ensure that staff in the home respond to each resident's fall in accordance with the home's falls prevention and management policies and procedures.

b) Ensure that after three identified residents, or any other resident has fallen, their falls prevention interventions are reviewed and revised as part of the post-fall assessment, in accordance with the home's falls prevention and management policies and procedures.

c) As part of the Falls Committee "falls tracking" activities in the home, post-fall assessments will be reviewed to determine if the staff complied with the home's falls prevention and management policies related to their response to the fall and the review of the resident's plan of care for falls prevention interventions. This review and tracking will be documented as part of the Falls Committee meeting minutes.

Grounds / Motifs :

1. The licensee has failed to ensure that where the Act or this Regulation required

the licensee of a long-term care home to have, institute or otherwise put in place any policy and procedure, the policy and procedure was complied with related to falls prevention and management.

In accordance with Ontario Regulation 79/10 s. 48 (1) 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury and also in accordance with Ontario Regulation 79/10 s. 30 (1)1, the licensee was required to ensure that staff in the home complied with the falls prevention and management program policies, procedures and protocols that were in place to reduce risk.

Specifically, staff did not comply with the licensee's i) "Safety Plan – Resident" policy and procedure with effective date September 2013 and ii) "CODE CARE: Come, Assess, React, Evaluate" policy and procedure with effective date May 2019, which were both part of the licensee's falls prevention and management program.

The home's "Safety Plan – Resident" policy and procedure included the following procedures under the title "Post Fall Management:"
- "Upon discovering a fall Code Care is called (see policy and procedure – Code Care)."
- "The interdisciplinary team will: c) complete an internal incident report, Post Fall Investigation and detailed progress note; e) Review Safety Plan interventions and modify plan of care as indicated."

The home's "CODE CARE: Come, Assess, React, Evaluate" policy and procedure included the following:
- "Policy: When a resident has a fall a CODE CARE will be paged by the staff member discovering the incident. All staff from that care area are required to respond immediately."
- "Procedure: 1. When a staff member discovers a resident on the floor he/she will immediately go to the nearest phone and page 'Code Care room xx'; 2. Registered staff, PT, PT aide, PSW, NRC and housekeeping from that care area will immediately respond to the location; 3. The staff member who paged the code will bring the resident's Safety Plan Intervention sheet from the paper chart AND a blank post fall investigation form. The person will be the "recorder; 7. Safety Plan Intervention sheet is to be reviewed and updated during the huddle. Review what strategies have been tried, what other interventions doe the group think could be implemented to prevent falls; 10. Upon completion of the huddle the registered staff

page "CODE CARE ALL CLEAR" will take the documentation, review and complete as necessary. Using this information the registered staff will completed the required incident reports, update the care plan and communicate results with appropriate managers, oncoming staff etc."

A) The home submitted a CIS report to the MOHLTC on a specific date which was related to an identified resident's fall.

The clinical record for this resident included documentation of the fall by the registered nursing staff member who had been notified of the fall.

During an interview an identified registered nursing staff member told Inspector #630 that they were familiar with the falls prevention and management program in the home and had received education regarding the policies and procedures. The staff member said that when a resident had fallen then code care would be called and the registered nursing staff was expected to respond and assess the resident. The staff member said they had been familiar with this identified resident and they had been working on during the shift when the resident fell. The staff member said they were notified of the fall by another staff member but could not recall when they had been notified. When asked if they were able to respond right away, the staff member said that they had sent down another staff member before they responded.

During an interview with another identified staff member they said they were familiar with the falls prevention and management program in the home and when a resident had a fall they were expected to respond and to do a post fall assessment. They said that if a code care was called while they were working in the home they would attend to assist, to assess for injury and to make recommendations. They said they would document a progress note right after the fall. The staff member said they were familiar with this identified resident and been working in the home on the date the resident fell. They said a staff member had called the code care. They said they responded to the code care by going to the desk and then they had been told by the registered nursing staff member to go and see the resident. They said when they arrived at the room there were two other staff present who said they were waiting for the nurse. They said it was about five minutes before the registered nursing staff member arrived to the resident's room.

During an interview with another staff member they said they were familiar with the

home's fall prevention and management program and had received education. They said that if a resident has fallen the PSWs were expected to ring for assistance and if the resident was safe then go and find someone to help. The staff member said they were familiar with this resident and they had been working on the shift during which the resident fell. This staff member said they had responded to the fall as they heard a callbell ringing. The staff member said that they went down to get the registered nursing staff member two times and that they had yelled that it was really an emergency. The staff member said it seemed like a long time before the registered nursing staff responded.

During an interview with another identified staff member they said when a resident had fallen in the home they were expected to respond to the code care. They said they had been familiar with this identified resident and they had responded to their fall on a specific date. They said when they responded there were two other staff in the resident's room and this was before code care had been called. They said another staff member responded before the registered nursing staff member and that one of the other staff members had to walk all the way down to the desk twice before the registered staff member came to the resident's room.

During an interview with another identified staff member they told Inspector #630 that they were familiar with the home's falls prevention and management program and had received education prior to working in the home. When asked what they were expected to do if a resident has fallen, they said that they were to call a code care go back to resident and put a pillow get the lift to get them up after the staff have responded. They said they were familiar with this identified resident and had been working on the day when the resident had fallen. The staff member said they did not know how long the callbell had been ringing prior to them responding as they had been in a room with another. The staff member said they thought it took the registered nursing staff member 10 to 15 minutes before they responded as they thought the nurse misunderstood which resident needed help.

During an interview the Executive Director (ED) said they were new to the position at the time of this incident. ED said that they had not personally been involved in investigating or reporting this CI and was therefor relying on the CIS documentation to answer questions about this incident. When asked what the staff member who discovered the fall did in response to the fall, the ED said they called down the hall and the other staff member stayed with the resident. The ED said they did not know if

the other staff member was there right away. When asked if they were able to determine how long the resident's bell had been ringing prior to the staff responding, the ED said no as they did not have the type of system to be able to tell that information. When asked how the registered staff were notified of the fall, the ED said they thought that one of the staff members had called down the hall. When asked how long it was between when the staff member notified the registered nursing staff of the fall and when they responded by going to the resident's room, the ED said they did not know. When asked if anyone brought forward a concern that another staff member was sent to respond prior to the registered nursing staff responding, the ED said they had not heard of that concern. The ED said that they had met with the identified registered nursing staff member after the incident regarding their response and were counselled that if they were called down the hall to assist then they needed to go. The ED said based on the home's Code Care policy staff were expected to go to the phone and call code care and staff were expected to respond to the fall immediately.

B) The clinical record for an identified resident showed the resident had nine documented falls during a specific time frame. Each documented fall was related to the a specific action taken by the resident without staff assistance. The written plan of care for the resident included specific interventions which were documented as having been updated on a specific date.

During an interview the Resident Assessment Instrument (RAI) Coordinator said they were familiar with this identified resident and they were considered to be at high risk for falls and continued to fall. They said this resident required specific interventions for mobility and falls prevention. The RAI Coordinator and Inspector #630 reviewed the post fall assessments that had been documented for this resident for a specific time frame, and it was identified that this resident had a nine documented falls. RAI Coordinator said this resident had a "Safety Plan Intervention" form that was part of their clinical record and the last time this form was updated was in May 2019. The RAI Coordinator said it was the expectation in the home according to the policy that the resident's fall prevention interventions would be reviewed and updated after each fall and that this was documented on the "Safety Plan Interventions" form. The RAI Coordinator said the interventions that were in place to minimize the resident's risk for falls were not effective.

During an interview with a Resident Care Coordinator (RCC) they said that they were

the lead for the Falls Prevention and Management Program in the home starting when they started in the RCC position in May 2019. The RCC said they were familiar with this resident and this resident was considered to be at risk for falls. The RCC acknowledged that there were interventions included in this resident's plan of care that were not effective interventions for this resident. The RCC said that the main intervention that was used within the home for falls prevention was bed or chair alarms and that the fall prevention and management committee had started in May 2019 to work on identifying other interventions to implemented for residents in the home to help minimize falls. The RCC said that it was the expectation in the home that the CODE Care policy would be complied with and that included the use of the "Safety Plan Intervention" sheet after each fall to review the strategies that had been tried and identify other interventions that could be implemented to prevent future falls.

C) The home submitted a Critical Incident System (CIS) report regarding a fall which another identified resident sustained on a specific date. This CIS report stated that this resident sustained a specific injury related to the fall.

The clinical record for this resident included a post fall assessment for the fall that had been reported in the CIS report and indicated that the fall was related to a specific type of action taken by the resident. The "Safety Plan Interventions" form for this resident was not completed until 14 days after the fall. This clinical record also showed that the resident had fallen on three other specific dates after the fall reported to the MOHLTC through the CIS. The "Safety Plan Interventions" form had no documentation after these falls. The written plan of care for this resident was not updated after each of these subsequent falls.

During an interview a Resident Assessment Instrument (RAI) Coordinator said they were familiar with this resident and they were considered to be at risk for falls. They said this resident had experience a fall which resulted in a specific type of injury. The RAI Coordinator acknowledged that based on the documentation in Risk Management this resident had experience three other falls. The RAI Coordinator and Inspector #630 reviewed the post fall assessments that had been documented for this resident during a specific time frame, and it was identified that there was a "Safety Plan Intervention" form that was part of their clinical record and the last time this form was not updated after each fall. The RAI Coordinator said it was the expectation in the home according to the policy that the resident's fall prevention

interventions would be reviewed and updated after each fall and that this was to be documented on the "Safety Plan Interventions" form.

D) During the inspection, Inspector #630 observed another identified resident using a specific mobility device on multiple occasions.

The clinical record for this identified resident documented the resident had seven documented falls during a specific time frame. The post-fall assessment for one of the falls showed the resident had sustained a specific type of injury. The "Safety Plan Interventions" form in this resident's record was last updated in 2016. The written plan of care for this resident had not been updated regarding mobility interventions or falls prevention interventions to reflect the interventions that were in place.

During an interview an identified registered nursing staff member said this resident had sustained two falls on a specific date. When asked what interventions were in place to help minimize their risk for falls, the staff member described why the resident was at risk for falls and did not describe interventions that were in place. The staff member said that the staff were using a specific mobility device at times for the resident at the request of the family.

During an interview with another staff member they said they were familiar with this resident and they were considered to be at risk for falls. When asked what intervention were in place to help minimize the resident's risk of falls, the staff member said that the staff had started using a specific mobility device with the resident as well as encouraged rest. The staff member said they could not think of any other interventions that were in place to help minimize resident's risk for falls.

During an interview with a Resident Assessment Instrument (RAI) Coordinator they said they were familiar with this identified resident and they were considered to be at risk for falls and continued to fall. The RAI Coordinator said this resident had a "Safety Plan Intervention" form that was part of their clinical record and the last time this form was updated was in 2016. The RAI Coordinator said the interventions that were in place to minimize the resident's risk for falls were not effective. The RAI Coordinator said that this resident had been using a specific mobility device at times and acknowledged that this had not been included in the plan of care as an intervention.

During an interview the Resident Care Coordinator (RCC) said they were familiar with this resident and this resident was considered to be at high risk for falls. When asked if the interventions that were in place effectively minimized the resident's risk of falls, the RCC said that staff should be looking at the interventions and the plan of care after each fall and they were not sure what alternative interventions had been tried or implemented for the resident. The RCC said they thought after one of the resident's falls the family had wanted the resident to use the specific mobility device. The RCC said that intervention should be included in the plan of care if it was being used for the resident. The RCC said it was the expectation that the Safety Plan Intervention sheet would be completed after each fall and acknowledged that these were not consistently being completed by the staff in the home. The RCC said they were working through the policy and identifying that there was so much involved in the post fall documentation and assessment and it took staff almost an hour to complete so looking at the paper work and trying to get it changed to an electronic format for all the pieces. They should be looking at the interventions that were in place as part of the post fall assessment and looking at what interventions had been tried and what ones should be trialled, and staff had not consistently been doing that. (630) [s. 8. (1) (b)]

The severity of this issue was determined to be a level three as there was potential for actual risk. The scope of the issue was a level three as it was widespread. The home had a level 3 history as they had previous non-compliance to the same sub-section of the legislation that included:

- Written Notification (WN) and Compliance Order (CO) issued May 7, 2019 (2019_778563_0013) with compliance due date May 31, 2019. The CO was complied July 2019.
- WN and CO issued February 19, 2019 (2019_778563_0006) with compliance due date March 31, 2019 which was closed with link May 7, 2019;
- WN and CO issued October 23, 2018 (2018_722630_0019) with compliance due date June 30, 2019. The CO was complied July 2019;
- WN and CO issued July 16, 2018 (2018_508137_0017) with compliance due date July 31, 2018 which was closed with link October 23, 2019;
- WN and Voluntary Plan of Correction (VPC) issued January 17, 2018 (2018_606563_0001);
- WN, CO and Director's Referral (DR) issued August 24, 2017 (2017_605213_0015)

with compliance due date September 8, 2017. This CO was complied October 5, 2017;
- WN and CO issued May 24, 2017 (2016_229213_0039) with compliance due date June 30, 2017 which was closed with link August 23, 2017;
- WN issued October 20, 2016 (2016_326569_0021).
(630)

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

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 18th day of October, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by AMIE GIBBS-WARD (630) - (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

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

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