Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date: December 5, 2023	
Inspection Number: 2023-1259-0007	
Inspection Type: Complaint Critical Incident	
Licensee: Maplewood Nursing Home Limited	
Long Term Care Home and City: Cedarwood Village, Simcoe	
Lead Inspector Brandy MacEachern (000752)	**Inspector Digital Signature** Brandy MacEachern Digitally signed by Brandy MacEachern Date: 2023.12.07 12:23:13 -05'00'
Additional Inspector(s) Leah Carrier (000748)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 31, 2023 and November 1, 2, 3, 6, 7, 8, 9, 10, 14, 15, 17, 20. 21, 23, 2023
The inspection occurred offsite on the following date(s): November 14, 20, 21, 2023

The following intake(s) were inspected:
Intake: #00090096 (2768-000012-23) Critical Incident System (CIS) report related to resident to resident abuse
Intake: #00093508 Complainant related to continence care products
Intake: #00093787 Complainant related to, plan of care, nursing and personal support services, menu planning, maintenance, and transferring and positioning techniques.
Intake: #00094258 (2768-000022-23) CIS report related to the fall of resident
Intake: #00094551 (2768-000023-23) CIS report related to the fall of resident
Intake: #00095751 Complainant related to nursing and personal support services and continence care and bowel management.
Intake: #00095988 Complaint of alleged neglect
Intake: #00096136 (2768-000024-23/2768-000024-23) CIS report related to an outbreak

Intake: #00097337 (2768-000027-23) CIS report related to an outbreak
Intake: #00098085 (2768-000028-23) CIS report related to the fall of resident
Intake: #00099001 (2768-000029-23) CIS report related to resident to resident abuse
Intake: #00099433 (2768-000032-23) CIS report related to resident to resident abuse
Intake: #00099532 Complaint related to nursing and personal support services
Intake: #00099699 (2768-000031-23) CIS report related to a medication incident
Intake: #00100500 Complaint related to staffing levels

The following intake(s) were completed as part of this inspection:
Intake: #00096569 (2768-000025-23) CIS report related to the fall of resident

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Continence Care
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident

The licensee has failed to ensure that a resident's plan of care set out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary
An anonymous complaint was received by the Director regarding a specific care program in the home. The complainant cited a specific resident as being affected by the care issues. Upon review of that resident's care plan, it identified the resident required a specific care product. The care plan directed staff to refer to the placard in resident's room for their specific product. During an observation of the resident's room, a product cubby was observed for the resident, but no placard or logo system was located on the cubby or in the room to inform staff what type of care product the resident used.

In interview with a staff member, they stated that the logo sticker placed on the resident's product cubby was how front-line staff know what care product to use for residents.

There was an increased risk to the resident that unclear direction was provided to staff regarding their care needs.

In an observation of the resident's room on November 14, 2023, Inspector #000748 did observe that a product logo was present in the room with the resident's name clearly marked on the logo. The logo identified the resident's specific care needs.

Sources: Clinical records, observations, staff interviews

Date Remedy Implemented: November 14, 2023

[000748]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident

The licensee failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provide direct care to the resident. Specifically, there was no bedside logo identifying a resident as a high-risk for falls, as per the resident's care plan.

Rationale and Summary
According to the home's Falls Program, Falls Intervention Risk Management Implementation (NDM-XVI-20), resident's who have been assessed at high-risk for falls will have a logo used to assist staff in identifying and monitoring those residents. A review of the resident's care plan identified the resident as high-risk for falls and directed staff to the resident's bedside logo. In interviews with three different staff members, they each identified the resident as high-risk for falls.

In an observation of the resident's room, no bedside logo identifying the resident as high-risk for falls was observed.

In Interview with Director of Care (DOC) it was reported that the resident was high-risk for falls and should have a bedside logo indicating such. The DOC brought Inspector #000748 to the resident's room but was unable to locate a high-risk for falls logo.

In a secondary observation of the resident's room on November 6, 2023, a high-risk for falls logo was in place above the resident's bed.

Sources: Observations, staff interviews

Date Remedy Implemented: November 6, 2023

[000748]

WRITTEN NOTIFICATION: Resident's Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

A) The licensee has failed to ensure that a resident's rights to proper care and services were respected, after the resident sustained an injury.

Rationale and Summary
The home submitted a Critical Incident Systems (CIS) report related to the injury of a resident. Later, the home submitted a subsequent CIS report alleging improper care and treatment of the resident related to the same incident.

In a review of the resident's progress notes, at the time of the incident the registered nursing staff member did not complete a full assessment of the resident to identify any new injuries.

In interview with the registered nursing staff member they were unable to report the actions they took.

The resident was at risk of unnecessary pain and suffering when their right to proper care and services were not respected after sustaining an injury.

Sources: Clinical record review, staff interviews

[000748]

B) The licensee has failed to ensure that a resident's rights to proper care and services were respected, when the resident was not transferred to hospital in accordance with their advanced directives.

Rationale and Summary
During interviews with two different staff members they each noted that the resident experienced a significant change in health prior to their transfer to hospital. The resident had a plan of care in place regarding advanced directives.

In interviews with a staff member and the Director of Care, they each indicated that after their review of the resident's progress notes, that the resident's care and needs could have been managed faster.

There was a risk that the resident was not provided with the care and services they required when the care was not provided in accordance with their advanced directives.

Sources: Clinical record review, staff interviews

[000752]

WRITTEN NOTIFICATION: Clear Direction

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident

A) The licensee failed to ensure that the written plan of care for a resident related to a specific care area set out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary
An anonymous complaint was submitted to the Director related to the availability of specific care products in the home. A specific resident was identified in the complaint as being affected by the availability of care products. In a review of the resident's clinical records, it was documented that the resident had a specific care device. In further record review of the resident's progress notes, physician's orders, medication administration record (MAR), and

treatment administration record (TAR), no further information was documented to support the resident utilizing this device.

In interview with a direct care staff, they reported that the resident did not have the specific device. During observations of the resident and their room, no related equipment or further evidence was located to support the resident using the specific device.

There was risk that the resident could receive improper care due to their care plan not setting out clear direction to staff and others who provide direct care to the resident.

Sources: clinical record review, staff interviews, observations

[000748]

B) The licensee has failed to ensure that a resident's plan of care related to a specific care intervention provided clear directions to the staff and others who provide direct care to the resident.

Rationale and Summary
During a record review of the resident's care plan it stated that the resident had a specific care intervention. In interviews with a registered nursing staff member and the Director of Care (DOC) they each advised that the specific care intervention was only implemented at certain times. Both the registered nursing staff member and DOC acknowledged that by the care plan not specifying that the resident only had the care intervention in place during specific times, that this was not providing clear direction.

There was risk that the resident could receive improper care due to their care plan not setting out clear direction to staff and others who provide direct care to the resident.

Sources: clinical record review; staff interviews

[000752]

WRITTEN NOTIFICATION: Needs of Residents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
Based on assessment of resident
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident after the resident sustained a specific injury.

Rationale and Summary
A resident sustained a specific injury. There was no documentation of a specific assessment found in the resident's health records. The Director of Care (DOC) said that the specific assessment should have been completed for the resident when they sustained the injury.

There was a risk that harm to the resident could not have been identified, and treatment provided when the assessment was not completed.

Sources: Health records for resident #011 and staff interviews

[000752]

WRITTEN NOTIFICATION: Staff Training

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 3.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

The licensee has failed to ensure that specific staff members were trained on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, before preforming their work responsibilities.

Rationale and Summary
During an interview with the Director of Care (DOC) they advised that they had specific staff working in the home. When asked if the staff were provided with training on the long-term care home's policy of abuse and neglect, the DOC informed they did not receive this training from the home.

In an interview with a staff member, they advised that they were not aware of the abuse and neglect policy, as they had never seen that document before.

There was a risk that the policy to promote zero tolerance of abuse and neglect would not be followed, when the staff are not trained on their roles and reasonability's outlined in the policy.

Sources: Staff interviews, Education records, Abuse and Neglect policy.

[000752]

WRITTEN NOTIFICATION: Falls Prevention and Management Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that when a resident fell, the Head Injury Routine (HIR) was completed at required assessment intervals.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure the home's falls prevention and management program was in place, and ensure it was complied with.

Specifically, staff did not comply with the licensee's Falls Prevention and Management policy which was part of the Falls Prevention and Management program.

Rationale and Summary
A Critical Incident System (CIS) was submitted to the Director regarding the fall of a resident. According to the CIS, a Head Injury Routine (HIR) was initiated for the resident.

During a record review of the resident's HIR, the documented assessment intervals were not completed as per the minimum follow-up as instructed on the HIR neurological record. A registered nursing staff member reported that the HIR was not completed in full as per policy.

There was increased risk that the resident would not receive treatment for potential injury after the home failed to assess the resident's neurological status as required by the HIR.

Sources: Clinical record review, staff interviews

[000748]

WRITTEN NOTIFICATION: Annual Evaluation of Continence Care Products

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (1) 5.
Continence care and bowel management
s. 56 (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated.

The licensee failed to ensure that an annual evaluation of residents' satisfaction with the range of continence care products was completed and taken into account when making purchasing decisions related to continence care products in 2022.

Rationale and Summary
The Director received an anonymous complaint related to availability of continence care products in the home. In an interview with the Administrator, they reported that they took a resident satisfaction survey regarding the range of continence products to residents' council for 2022 but could not confirm when the evaluation was last completed. Inspector #000748 requested related documents to confirm completion. In an interview with the Director of Care (DOC), Inspector #000748 requested copies of the resident satisfaction evaluation related to the range of continence products in the home, to which the DOC stated that the home did not keep copies of the evaluations. Inspector #000748 questioned if the resident satisfaction evaluations are taken into consideration when making continence product purchasing decisions, to which the DOC shook their head "no." In a follow up interview with the Administrator, they stated that they do not have documentation to support that an evaluation of residents' satisfaction with the range of continence care products was completed and used to make purchasing decisions in 2022.

Resident's were at risk of their needs and preferences not being respected when the home made purchasing decisions related to continence care products for the home.

Sources: Staff interviews, record review

[000748]

WRITTEN NOTIFICATION: Continence Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (h) (iv)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,

(iv) promote continued independence wherever possible

The licensee failed to ensure that two different residents were provided with a continence care product that promoted the resident's continued independence.

A) **Rationale and Summary**
A complaint was received by the Director regarding the availability of incontinence products, specifically one type of product, in the home. A resident that was historically provided with this type of product was no longer offered it and had been provided with an alternative. It was documented in the resident's progress notes that they reported the change of incontinence product had impacted their activities of daily living.

As per the homes Continence Care Program (Nursing Department Manual NDM-XI-10), the policy identified that an individualized continence care plan was to be based on both resident preferences and assessed needs.

Inspector #000748 questioned the Director of Care (DOC) how the home is respecting resident preferences and the DOC replied that there was no difference between the two products.

In interview with a registered nursing staff member, they stated that, if the resident had a preference for a certain continence product, then that must be respected as it was their right.

There was risk that the resident's quality of life was impacted when their provided continence care product did not promote their independence.

Sources: resident and staff interviews, clinical record review, program policy review

[000748]

B) **Rationale and Summary**
An anonymous complaint was received by the Director regarding the availability of incontinence products, specifically one type of product, in the home. A resident that was

historically provided with this type of product was no longer offered it and had been provided with an alternative.In interview with a direct care staff, they reported that the resident did not respond well to the change in product types, they stated that the resident's preference was the previous type of product.

As per the homes Continence Care Program (Nursing Department Manual NDM-XI-10), the policy identified that an individualized continence care plan was to be based on both resident preferences and assessed needs.

There was risk that the resident's quality of life was impacted when their provided continence care product did not promote their independence.

Sources: resident, staff and POA interviews, program policy review

[000748]

WRITTEN NOTIFICATION: Annual Evaluation and Updates

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (3) (b)
Responsive behaviours
s. 58 (3) The licensee shall ensure that,
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices

The licensee has failed to ensure that at least annually, the matters referred to in O. Reg 246/22 s.58 (1) were evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary
When Inspector #000758 requested to review the home's Responsive Behaviors Nursing Department Manual, the Director of Care (DOC) reported that the document was not updated.

The approved date listed on the title page of the manual stated November 17, 2020, and there was no mention of any revisions or re-evaluations to the document.

There was a risk to the resident's when the information and direction provided to staff caring for residents with responsive behaviors, found within the Responsive Behaviors Nursing Department Manual may have not been up to date according to evidence-based practices or prevailing practices.

Sources: Responsive Behaviors Nursing Department Manual, DOC Interview

[000752]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that when a resident demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including an assessment.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure the home's responsive behaviours program was in place, and ensure it was complied with. Specifically, the licensee failed to complete a Responsive Behaviours Response Report assessment on a resident following an incident of responsive behaviours.

Rationale and Summary
A Critical Incident System (CIS) Report was submitted to the Director, related to an incident of

responsive behaviours of a specific resident. During a review of the resident's clinical records, the incident was documented in the resident's progress notes, however, there was no Responsive Behaviour Response Report documented in the resident's assessments. According to the home's Responsive Behaviors Management policy, Part B: Interventions stated that upon occurrence of an episode of physically responsive behaviours, registered staff were to complete a Responsive Beahviours Response Report to review the exhibited behaviour, strategize to minimize or eliminate the recurrence of the behaviour, and to determine effectiveness of current strategies.

In separate interviews with the Resident Assessment Instrument (RAI) Coordinator and the Director of Care (DOC), both interviewees identified that a Responsive Behaviour Response Report should have been completed after this incident.

There was risk that the resident's needs related to responsive behaviours were unmet when the home failed to implement their policy related to assessment after an incident of physically responsive behaviours.

Sources: clinical record reviews; policy review; staff interviews

[000748]

WRITTEN NOTIFICATION: Resident Hand Hygiene

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control.

The licensee has failed to ensure all staff participated in the implementation of the Infection Prevention and Control Program (IPAC) in accordance with IPAC Standard for Long-Term Care Homes.

The IPAC Standard for Long-Term Care Homes, indicated under section 10.1 that the licensee should ensure that the hand hygiene (HH) program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

O. Reg. 246/22, s. 102 (2)(b) requires the licensee to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary
During observations of a meal service, Inspector #000752 observed staff offer residents aloe wipes for hand hygiene prior to their meal. The Inspector noted that the aloe hand wipes did not contain alcohol. A staff member confirmed in interview that aloe wipes were always what was used for resident HH prior to meals. The Infection Prevention and Control (IPAC) Lead additionally confirmed in an interview that the aloe wipes were offered to residents as a form of HH prior to meals and snacks, and do not contain any alcohol.

In an interview with the home's Public Health contact, they had advised that the home should have been using Hand Hygiene products with 70- 90% alcohol content, and that they were not aware of home using aloe wipes for resident hand hygiene.

The home's Resident Hygiene and Grooming Policy stated that all residents would be provided or offered assistance with hand hygiene before and after all meals and snacks. The home's Hand Hygiene Policy stated that hand hygiene may be accomplished using an alcohol-based hand rub or soap and running water.

Staff not implementing the home's IPAC program by not providing proper hand hygiene with ABHR to residents prior to their meal service, put residents at risk of potentially spreading healthcare associated infections.

Sources: Staff interviews, Hand Hygiene Policy, Resident Hygiene and Grooming Policy, Dining observations, IPAC Observations.

[000752]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that drugs were stored in an area or a medication cart, that was secure and locked.

Rationale and Summary
While on a resident unit of the home an observation was made of three open bins holding topical drugs, sitting out on the ledge of the nursing desk. A registered nursing staff was requested to come to the desk, and they acknowledged that these were prescription creams sitting on the desk that should have been locked in the medication room. The registered nursing staff advised that the direct care staff should have reported when they were finished using the creams so that they could have been properly put away. The registered nursing staff took the three bins and locked them in the medication room.

There was a risk that residents could have accessed these topical drugs when they were left out on the nursing desk.

Sources: Unit observation, staff interview

[000752]

WRITTEN NOTIFICATION: Documenting Medication Incidents

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health

The licensee has failed to ensure that a medication incident involving a resident was documented.

Rationale and Summary
A complaint was received by the Director related to missed medications for a resident.

It was identified that the resident did not receive all medications as prescribed, which the Director of Care (DOC) and a staff member both indicated would have required an incident report. When an incident report was requested from the DOC they were unable to locate one, and when the staff member was asked for an incident report they stated there was not one completed.

There was a risk to the resident that these missed drugs were not discovered and appropriate actions could not be taken to assess and maintain the resident's health.

Sources: Staff interviews, medication administration record, prescriber's order.

[000752]

WRITTEN NOTIFICATION: Reporting Medication Incidents

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider.

The licensee has failed to ensure that a medication incident involving a resident was reported to the resident's substitute decision-maker and their attending physician.

A) **Rationale and Summary**
A Critical Incident System (CIS) report submitted to the Director, indicated that a medication incident had occurred to a resident.

During a review of the prescriber's order and the medication administration record (MAR) it was identified that there had been four different medications not given to the resident as prescribed. The resident's progress notes indicated that the Power of Attorney (POA) was notified of the one missed medication, but there was no documentation found regarding the other three medications.

In an interview with the resident's provider, they informed that when they spoke with the POA of the resident, they notified them of two medication errors, but they were not made aware of the other two missed medications.

There was a risk to the resident when these medication incidents were not reported to their POA, that the POA would not be able to make informed decisions in the best interest of the

resident's care.

Sources: Critical Incident System (CIS) report, progress notes, medication administration record, prescribers order, staff interviews

[000752]

B) **Rationale and Summary**
A Critical Incident System (CIS) report submitted to the Director, indicated that a medication incident had occurred to a resident.

During a review of the prescriber's order and the medication administration record (MAR) it was identified that there had been four different medications not given to the resident as prescribed. The medication incident report indicated that the resident's physician had not been notified of the medication errors, which a registered nursing staff confirmed in an interview that they failed to notify the physician.

The Director of Care (DOC) was aware of the incident and in an interview advised that resident's physician was aware of the one missed medication but could not confirm if they had been notified of the other medication errors.

In an interview with the resident's physician, they stated that they were notified of the one missed medication, but not all the medication errors. They said that they would have expected registered nursing staff to have informed them of each of these.

There was a risk to the resident when these medication incidents were not reported to the attending physician that appropriate actions could not be taken to assess and maintain the resident's health.

Sources: Medication Administration record, Medication incident report, Prescribers order, Staff interviews.

[000752]

C) The licensee has failed to ensure that a medication incident involving a resident was reported to the attending physician and the Director of Care.

Rationale and Summary
A complaint was received by the Director related to missed medications for a resident.

It was identified that the resident did not receive the three medications as prescribed. During an Interview with the resident's attending physician, they informed that they were not made aware of any missed medications for the resident, and they would have expected registered nursing staff to communicate this to them. The Director of Care (DOC) also stated in an interview they had not been made aware of this medication incident.

During a review of the resident's progress notes there was no documentation found related to notifying the attending physician or DOC of missed medications.

There was a risk to the resident that these missed drug were not reported and appropriate actions could not be taken to assess and maintain the resident's health.

Sources: Staff interviews, medication administration record, prescriber's order, progress notes.

[000752]

COMPLIANCE ORDER CO #001 Altercations and Other Interactions Between Residents

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59 Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including (b) identifying and implementing interventions.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

A) Develop and implement a process for the Director of Care to oversee care related to responsive behaviors is provided to a specific resident.

A) Maintain a documented record of this process and implementation.

C) Train all Personal Support Workers, Registered Practical Nurses, and Registered Nurses who work on a specific unit, and specific staff who provide specific care to a specific resident on the resident's plan of care related to responsive behaviors.

D) Maintain a documented record of completed training and a list of the staff who completed the training.

Grounds
The licensee failed to ensure that interventions to minimize the risk of altercations and potentially harmful interactions between and among residents were implemented for a specific resident.

A) **Rationale and Summary**
A Critical Incident System (CIS) report was submitted to the Director alleging an incident of responsive behaviors of a resident toward a co-resident. The CIS report stated that the resident had a specific intervention, which was not in use at the time of the incident.

In interview with the Director of Care (DOC) they informed that the resident's specific intervention was included in their plan of care, but staff had not implemented it at the time of the incident resulting in an altercation between two residents.

There was risk of harm to the residents when the home failed to ensure that interventions to minimize harmful interactions between residents were implemented.

Sources: Record review, staff interview

[000748]

B) **Rationale and Summary**
A Critical Incident System (CIS) report was submitted to the Director alleging an incident of responsive behaviors of a resident toward a co-resident. The CIS report stated that the resident had a specific intervention, which was not in place at the time of the incident.

In a review of the resident's care plan, the resident was to have a specific intervention in place. In an interview with a staff member, they confirmed that resident the resident was to have this specific intervention in place. The Director of Care (DOC) reported that the resident's intervention was not in place as it should have been, which resulted in an altercation between two residents.

There was actual harm to a resident when interventions to minimize the risk of potentially harmful interactions between residents were not implemented.

Sources: Staff interviews, clinical record review

[000748]

This order must be complied with by January 12, 2024

COMPLIANCE ORDER CO #002 Administration of Drugs

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155

(1) (a)]:
The licensee shall:

A) Complete weekly interdisciplinary audits by the DOC or delegated registered nursing staff member and the Pharmacy Provider of all new medication orders for residents to ensure those orders have been reflected accurately in those resident's medication administration records. Audits will continue until the Compliance Order is complied by an inspector;

B) Maintain a record of completed audits;

C) Provide training to all registered nursing staff, including all staff working through an agency on the home's order processing procedures for newly prescribed or changes to medication orders;

D) Maintain a record of completed training and a list of the staff who completed the training

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

A) **Rationale and Summary**
A complaint was received by the Director indicating that a resident did not receive the three medications as prescribed for a specific time frame.

During a review of the resident's paper chart, there was a physician order for three medications, the boxes for the first and second nurse checks were both blank on the order. When reviewing the resident's Medication Administration Record (MAR) these medications were not found.

During interviews with a staff member and the Director of Care (DOC) they each confirmed that the resident's prescriber's order had not been processed appropriately and did not have two registered nursing staff checks on the order as expected. Therefore, the resident did not receive

three medications as prescribed.

There was a risk to the resident's health when these drugs were not given in accordance with the directions for use specified by the prescriber.

Sources: Staff interviews, clinical records.

[000752]

B) **Rational and Summary:**
The Critical Incident System (CIS) report submitted to the Director indicated that a resident did not receive a medication as ordered by the prescriber. During a record review of the resident's mediation orders and Medication Administration Record (MAR), and during an interview with a registered nursing staff member it was identified that the orders from the physician were not followed, as such:

1) One medication was not administered to the resident until ten days after the prescriber's order had been written
2) A second medication was never administered to the resident as prescribed
3) A third medication was not administered to the resident until ten days after the prescriber's order had been written

4) A fourth medication order stated a specific dose and frequency, the resident's MAR indicated the medication was administered at an incorrect dose and frequency for ten days after the prescriber's order had been written

The Director of Care (DOC), a registered nursing staff, and the physician each advised in interviews that the prescriber's order had not been processed appropriately and did not have two registered nursing staff checks on the order as expected. The DOC reported that their pharmacy did not process the order correctly, but that if the registered nursing staff had completed first and second checks then these errors could have been identified. The two boxes on the paper order for nurse checks were both blank. Additionally, the home's MediSystem Order Processing Procedures Policy stated that all orders must be checked by two different

nurses.

There was a risk to the resident's health and wellbeing when these drugs were not given in accordance with the directions for use specified by the prescriber.

Sources: Staff interviews, clinical records.

[000752]

This order must be complied with by January 12, 2024

This compliance order is also considered a written notification and is being referred to the Director for further action by the Director.

COMPLIANCE ORDER CO #003 General Requirements

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (c)]:
The licensee shall:

A) The Director of Care will review the College of Nurses of Ontario (CNO) Practice Standard for Documentation and maintain a documented record of the review.

B) Review the home's registered nursing staff job descriptions related to documentation and update to align with CNO Practice Standard for Documentation and maintain a documented record of the review.

C) Train all registered nursing staff on the CNO Practice Standard for Documentation and their job descriptions related to documentation.

D)) Maintain a record of completed training and a list of the staff who completed the training.

Grounds
In accordance with FLTCA s. 11 (1) (a) the licensee shall ensure that there is an organized program of nursing services for the home to meet the assessed needs of the residents. Specifically, the licensee has failed to ensure that any actions taken with respect to two residents under the nursing services program, including interventions and the resident's responses to interventions are documented.

A) **Rationale and Summary**
A complaint was received by the Director concerning the care that was provided to a resident.

During an interview with a registered nursing staff, they reported they had made multiple, specific interventions to the resident's care.

In a review of documentation these specific interventions were not found. The Director of Care (DOC) advised in an interview that they believed there were specific interventions that took place, but they did not see any documentation of those interventions, as expected.

There was a risk that the resident could have received inconsistent care due to the lack of documented interventions.

Sources: Clinical records, staff interviews

[000752]

B) **Rationale and Summary**

An anonymous complaint was submitted to the Director related to the home no longer supplying specific care products to residents. A specific resident was identified in the complaint as being affected by the change. In interview with a staff member, they reported that the resident did not respond well to the change of products. In interview with the Director of Care (DOC) they reported that almost all residents who used the specific care product were changed to an alternative option, and that the change was completed without assessing the residents for this change. In a follow up interview with the DOC, they stated that the change and resident responses to the change would likely not have been documented in residents' progress notes. In a review of the resident's clinical records, no progress notes, or assessments prior to the inspection, were documented relating to the resident's change in care products, or the resident's response to the change.

The resident was at risk of increased discomfort related to their specific care product when the home failed to document the resident's intervention and response to the intervention after ceasing to offer the resident's preferred care product.

Sources: Clinical records, staff interviews, POA interview

[000748]

This order must be complied with by February 9, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing

(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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