Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

**Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée**


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111


## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 10, 2020 | 2020_640601_0005 | 002478-20, 003263-20, 003650-20, 003747-20 | Complaint |

### Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

### Long-Term Care Home/Foyer de soins de longue durée

Hope Street Terrace
20 Hope Street South PORT HOPE ON L1A 2M8

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

KARYN WOOD (601)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): February 13, 14, 20, 21, 24, 25, March 2, 3, 4, 5, 6, 9, 10 and 11, 2020.**

**The following intakes were completed in this Complaint Inspection:**

**Three logs related to allegations of staff to resident neglect and care concerns.**

**One log related to an unexpected death.**

**PLEASE NOTE: A Voluntary Plan of Correction (VPC) related to O. Reg. 79/10, s. 30 (2), identified in concurrent inspection #2020_640601_0006 on June 10, 2020, was issued in this report.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Physician, Nursing Consultant (NC), Nutritional Care Manager (NCM), RAI-Coordinator (RAI), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Maintenance Worker (MW), Coroner, Police Officer, residents and their family.**

**The inspector also reviewed resident health care records, the licensee's relevant policies and procedures, observed the delivery of resident care and services, including staff to resident interactions.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Falls Prevention**
**Hospitalization and Change in Condition**
**Medication**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Safe and Secure Home**
**Skin and Wound Care**

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

**7 WN(s)**
**5 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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).**

**s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**s. 6. (12) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an explanation of the plan of care. 2007, c. 8, s. 6 (12).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #001's written plan of care set out clear directions to staff and others who provide direct care to the resident related to pain management prior to specified treatment.

Two complaints were received by the Director on specified dates related to allegations of staff to resident neglect regarding multiple personal care concerns.

Inspector #601 reviewed resident #001's physician order and the following pain management was prescribed on a specified date by the Nurse Practitioner (NP):

-A specified pain medication to be given three times a day for pain at specified times.

-A specified pain medication to be given by mouth every six hours, as needed for pain.

-Make sure to give the specified pain medication thirty minutes before the specified treatment.

Inspector #601 reviewed resident #001's Medication Administration Record (MAR) for a specified period of time and the pain medication order that was written by the NP on a specified date directed to:

-Give the specified pain medication (routine or when required) thirty minutes before the specified treatment, liaison with wound care nurse to establish when the specified treatment will be completed.

Inspector #601 reviewed resident #001's MAR for a specified period of time and identified that resident #001 did not have evidence they received an extra dose of the specified pain medication thirty minutes prior to their specified treatment, as prescribed by the NP on specified dates.

Inspector #601 reviewed resident #001's Treatment Administration Record (TAR) for a specified period of time and identified the resident had specified pain levels during the specified treatment when there was no evidence the extra dose of pain medication was administered thirty minutes prior to the resident's specified treatment.

During an interview, RN #104 indicated to Inspector #601 that resident #001 experienced pain with the specified treatment.

During an interview, RPN #108 indicated to Inspector #601 that resident #001 required pain medication thirty minutes prior to their specified treatment. RPN #108 further indicated the resident's specified treatment was monitored throughout the day and sometimes the treatment was required twice a day.

During an interview, RPN #109 indicated to Inspector #601 they had administered resident #001's specified pain medication routine dose or as required dose thirty minutes prior to the specified treatment. RPN #109 indicated that it was not possible to complete the resident`s specified treatment at the same time every day due to having to coordinate other resident treatments and providing care to other residents. RPN #109 indicated the specified treatment was often completed thirty minutes after the resident received their

routine pain medication and the as required pain medication was not administered.

During a telephone interview, the NP indicated to Inspector #601 that resident #001 was having discomfort with the specified treatment. The NP further indicated that on a specified date, they had prescribed for resident #001 to receive a specified pain medication three times a day and a specified pain medication every six hours, as required. The NP indicated they also prescribed for resident #001 to receive a specified pain medication thirty minutes prior to their specified treatment, in addition to the regular prescribed specified pain medication three times a day.

During an interview, the Director of Care (DOC) indicated resident #001 had been prescribed a specified pain medication three times a day and a specified pain medication every six hours, as required. The DOC indicated that on a specified date, the NP had prescribed for the resident to receive a specified pain medication thirty minutes before the resident's specified treatment. The DOC indicated registered staff had been coordinating when the specified treatment was completed with the resident's regular dose of a specified pain medication at specified times. The DOC further indicated the order written by the NP on a specified date, should have been clarified by the registered staff transcribing the order to provide clear direction to the registered staff to administer the as required specified pain medication thirty minutes prior to the resident's specified treatment.

The licensee failed to ensure that resident #001's written plan of care set out clear directions to staff and others who provide direct care to the resident related to pain management prior to the resident's specified treatment. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with the resident's physician and each other in the assessment of resident #001, so that their assessments were integrated, consistent with and complemented each other.

A complaint was received by the Director on a specified date related to resident #001 and allegations of staff to resident neglect regarding multiple care concerns.

Inspector #601 reviewed resident #001`s Medication Administration Record (MAR) and the resident`s progress notes for a specified period of time, the resident was given a specified medication on a number of specified dates for an identified symptom.

During an interview, RPN #109 indicated to Inspector #601 and Inspector #623 that resident #001 had the identified symptom once or twice on their shift and they had not notified the resident's physician or the Nurse Practitioner (NP).

During an interview, RN #104 indicated to Inspector #601 that on a specified date they asked the NP to assess resident #001 due to the resident having the identified symptom the day prior and to assess the resident's specified skin condition.

During a telephone interview, the physician indicated to Inspector #601 they were not aware and should have been made aware that resident #001 had the specified skin condition and that resident #001 had the identified symptom on a number of specified dates.

During an interview, the Director of Care (DOC) indicated to Inspector #601 the registered staff should have collaborated with resident #001's physician when the resident was experiencing the identified symptom.

The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with the physician and each other in the assessment of the resident when they developed the identified symptom. Resident #001 had received medication for the identified symptom on a number of specified dates and their specified skin condition had deteriorated during this time. The physician was not informed of the resident having the specified skin condition, when the nurse reported the resident was experiencing specified symptoms. On a specified date, the NP was informed of the resident experiencing the identified symptom and assessed resident #001's specified skin condition and determined resident #001's identified symptom was due to resident #001's specified skin condition. [s. 6. (4) (a)]

3. A complaint was received by the Director on a specified date related to resident #001 and allegations of resident neglect with care being provided.

Inspector #601 reviewed resident #001's progress notes related to the resident's change in condition and pain management for a specified period of time and identified the following:

-On a specified date and time, RPN #105 documented they were not able to arouse the resident to take their prescribed medication, and had identified symptoms

-On a specified date and time, RN #121 documented that resident #001 had another identified symptom.

-On a specified date and time, RN #124 documented they had spoken with resident #001's physician and received orders to administer pain medication subcutaneously.

Inspector #601 reviewed resident #001's Medication Administration Record (MAR) and on a specified date, RPN #122 documented resident #001 refused a specified medication orally at three specified times.

During a telephone interview, RN #121 indicated to Inspector #601 that on a specified evening shift, resident #001 was assessed and found to have identified symptom. RN #121 further indicated they had spoken to the complainant about the resident's condition at the time of the assessment. RN #121 indicated the complainant was concerned that resident #001 was not taking their oral medication and how the resident's pain would be managed. RN #121 discussed specified measures with the resident's SDM and informed them that physician orders could be obtained to give the resident's medication subcutaneously for pain management. RN #121 indicated to Inspector #601 that resident #001's physician was not contacted during the night. RN #121 indicated that resident #001's physician was not made aware that RPN #122 was not able to arouse the resident to take their prescribed medication on a specified date and time, and that the resident had specified symptoms during an identified night shift.

During an interview, RN #124 indicated to Inspector #601 and Inspector #623 that on a specified date, they called resident #001's physician as the resident's SDM had spoken with the night nurses about implementing specified care measures. RN #124 indicated they informed the physician that resident #001's SDM was requesting specified care measures to be put into place. RN #124 further indicated that resident #001's physician prescribed for resident #001 to receive a specified pain medication subcutaneously.

During an interview, the physician indicated to Inspector #601 and Inspector #623 that they received a call from the nurse on a specified date. The physician indicated they prescribed for resident #001 to receive a specified pain medication subcutaneously and another specified subcutaneous medication for comfort measures, when required. According to the physician, they were not made aware and should have been made aware that resident #001 was not taking their routine oral medications. The physician indicated they were informed the family were concerned about the resident's pain management due to the resident's non-verbal cues. The physician indicated they would

have expected the resident’s routine medications would have been given.

During an interview, the Director of Care (DOC) indicated to Inspector #601 the registered staff should have collaborated with resident #001’s physician regarding the resident not taking their oral medication on the specified dates.

The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with the physician and each other in the assessment when the resident was not able to swallow their oral medication and when the resident had a change in condition on the specified dates. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the resident’s Substitute Decision-Maker (SDM), and any other persons designated by the resident were given an explanation of the plan of care related to the management of the resident’s specified skin condition.

A complaint was received by the Director on a specified date related to the management of resident #001's specified skin condition and the Substitute Decision Maker (SDM) not being informed of the deterioration of the resident's specified skin condition.

Inspector #601 reviewed resident #001’s progress notes for a specified period of time and the following was documented:

-On a specified date and time, RN #102 documented a description of resident #001's skin condition and that a specified treatment had been applied.

-On a specified date and time, RN #113 documented a description of resident #001's skin condition and there was a specified change in the skin condition and the treatment being applied to the resident's specified skin condition.

-On a specified date and time, RN #106 documented a description of resident #001's specified skin condition and the skin assessment indicated the resident's specified skin condition was assessed.

-On a specified date and time, RPN #107 documented that resident #001’s specified skin condition was worsening.

-On a specified date and time, RPN #109 documented they had left a message for the SDM to return call to be updated on the resident's specified skin condition.

-On a specified date and time, the Nurse Practitioner (NP) documented that resident #001's SDM was alarmed when the NP recommended a specified intervention for resident #001's specified skin condition.

During an interview, the Director of Care (DOC) indicated to Inspector #601 that registered staff should have notified resident #001's SDM when there was a change in the resident's treatment of their specified skin condition.

The licensee failed to ensure that the resident's SDM, and any other persons designated by the resident were given an explanation of the plan of care related to the management of the resident's specified skin condition. [s. 6. (12)]

***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 ensure that residents written plan of care set out clear directions to staff and others who provide direct care to the resident, that staff and others involved in the different aspects of care collaborate with the resident's physician and each other in the assessment of resident so that their assessments are integrated, consistent with and complement each other and that the resident's Substitute Decision-Maker (SDM), and any other persons designated by the resident are given an explanation of the plan of care, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

**Specifically failed to comply with the following:**

**s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**
**(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).**
**(b) is on at all times; O. Reg. 79/10, s. 17 (1).**
**(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
**(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
**(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
**(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
**(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that, in the case of a system that uses sound to alert staff, was properly calibrated so that the level of sound was audible to staff.

During an interview, the complainant indicated to Inspector #601 the nurse would silence the call bell alarms during the night from the nurse`s station.

During a telephone interview, RN #106 indicated to Inspector #601 they have silenced the call bell alarms from the nurse`s station during the night to avoid waking residents. RN #106 further indicated the call bell light would remain activated and the PSWs would answer the call bell in the resident’s room.

During separate interviews, PSW #117, RN #104, RN #113, RPN #109 indicated they were aware the call bell alarms could be silenced at the nurse’s station and indicated they always went to the resident’s room to turn off the call bell alarm.

Inspector #601 reviewed the communication report on Point Click Care (PCC) on a specified date, informing staff to not silence the call bell system at any time and that call bells should be answered and shut off in the rooms.

During an interview, RAI/RPN #103 and the Maintenance Worker #131 indicated to Inspector #601 the call bell system would allow staff to silence the call bell alarms at the nurse`s station and the call bell light would remain activated at the resident`s room. RAI/RPN #103 further indicated the call bells that were activated when the call bell system was silenced would need to be reset at the point of activation. RAI/RPN #103 indicated someone had silenced the call bell alarms on a specified date and all the call bells had to be reset in the resident`s rooms. They further indicated staff were informed in the PCC communication report to not silence the call bell system and to shut off all call bells in the resident’s rooms.

The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, in the case of a system that uses sound to alert staff, was properly calibrated so that the level of sound was audible to staff. [s. 17. (1) (g)]

***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 ensure that the home is equipped with a resident-staff communication and response system that, in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (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. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any action taken with respect to resident #001 under the Continence Care program, including assessments, reassessments, interventions and the resident's responses to the intervention were documented.

A complaint was received by the Director on a specified date related to continence care.

Review of resident #001's 24-hour admission care planning assessment and written care plan for a specified date by Inspector #601, identified the resident was incontinent of bowel and bladder.

Inspector #601 reviewed resident #001's Point of Care (POC) documentation for a specified period of time and identified the PSWs did not document in POC if the resident had a bowel movement on a number of specified dates.

Inspector #601 completed a record review of the licensee's Continence Management Program policy that directed care staff to complete all relevant and required

documentation and verify documentation accuracy; report to the nurse any changes in a resident's functional status, elimination patterns, needs, or inability to void or evacuate the bowels within the last three consecutive days.

During separate interviews, PSW #116, RN #106, PSW #117, PSW #120, RN #102, RN #113, RPN #108, and RPN #109 indicated to Inspector #601 that resident #001 was incontinent of bladder and bowel. They further indicated the PSWs should document when the resident had a bowel movement in POC.

During an interview, the Director of Care (DOC) indicated to Inspector #601 that PSWs were responsible to document when the resident had a bowel movement in POC.

The licensee failed to ensure that any action taken with respect to resident #001 under the continence care program related to documenting bowel movements, including assessments, reassessments, interventions and the resident's responses to the intervention were documented. [s. 30. (2)]

2. The licensee has failed to ensure that any action taken with respect to resident #001 under the Nutrition and Hydration program, including assessments, reassessments, interventions and the resident's responses to the intervention were documented.

Review of resident #001's 24-hour admission care planning assessment by Inspector #601 identified the resident required specified assistance from one staff for meal and fluid intake.

Review of resident #001's written care plan initiated on a specified date by Inspector #601 indicated the resident required specified assistance with meals, as required.

Review of resident #001's written care plan on a specified date by Inspector #601, indicated the resident required increased assistance from staff for all meal and fluid intake.

Review of resident #001's Point of Care (POC) documentation for eating for a specified period of time by Inspector #601, identified the PSWs documented that resident #001 received specified assistance at meal time for a specified period. The resident's POC documentation completed by the PSWs for a specified period of time identified that resident #001's level of assistance required at meal time varied.

Inspector #601 reviewed resident #001's POC documentation for a specified period of time identified the PSWs did not document in POC the resident's meal or fluid intake on a number of specified dates.

Inspector #601 completed a record review of the licensee's Food and Fluid Monitoring policy that directed care staff to document resident food and fluid intake after meals and snacks including any special items and nutritional supplements, either on paper or electronically. Food and fluid intake must be recorded as close as possible to consumption of meal or snack.

During separate interviews, PSW #116, PSW #120, RN #102, and RN #113 indicated to Inspector #601 that resident #001 required specified assistance for meals when they were admitted to the home. PSW #116, PSW #120, RN #102, RN #113, and RPN #108 indicated resident #001's meal and fluid intake had declined, the resident required increased specified staff assistance for eating. They further indicated the PSWs should document the resident's meal and fluid intake in POC.

During an interview, the Director of Care (DOC) indicated to Inspector #601 that PSWs were responsible to document the resident meal and fluid intake in POC.

The licensee failed to ensure that any action taken with respect to resident #001 under the nutrition and hydration program related to documenting meal and fluid intake, including assessments, reassessments, interventions and the resident's responses to the intervention were documented. [s. 30. (2)]

3. The licensee has failed to ensure that any action taken with respect to resident #001 under the Skin and Wound Care program, including assessments, reassessments, interventions and the resident's responses to the intervention were documented.

Review of resident #001's 24-hour care planning assessment by Inspector #601 identified the resident was admitted to the home with a specified skin condition.

Inspector #601 reviewed resident #001 written care plan initiated on a specified date that indicated the resident had impaired skin integrity related to a specified skin condition. According to the written care plan resident #001 had specified risk factors for skin impairment. The interventions included to reposition every two hours during the day and overnight; avoid laying on back; turning schedule at the bedside; monitor specified area for redness and if noted return to turning and repositioning the resident every hour.

Inspector #601 reviewed resident #001's POC documentation for a specified period of time and identified the PSWs did not document in POC when the resident was turned and repositioned for a specified period of time.

Inspector #601 reviewed resident #001's written turning and repositioning documentation for a specified period of time and staff were documenting when the resident had been turned and repositioned.

During separate interviews, PSW #116, RN #106, PSW #117, Agency RN #118, PSW #120, RN #102, RN #113, RPN #108, and RPN #109 indicated to Inspector #601 that resident #001 was turned and repositioned every two hours when the resident was admitted to the home. They further indicated the PSWs should document when the resident was turned and repositioned in POC and more recently had been documenting the care provided on a written form that was kept at the resident's bedside.

During an interview, the DOC indicated to Inspector #601 that PSWs were responsible to document when the resident was turned and repositioned in POC prior to the written turning and repositioning form being initiated on a specified date that was kept at the resident's bedside.

The licensee failed to ensure that any action taken with respect to resident #001 under the Skin and Wound Care programs, related to documenting when the resident was turned and repositioned for a specified period of time, including assessments, reassessments, interventions and the resident's responses to the intervention were documented. [s. 30. (2)]

4. The licensee has failed to ensure that any action taken with respect to resident #002 under the Continence Care program, including assessments, reassessments, interventions and the resident's responses to the intervention were documented.

Non-Compliance was identified while inspecting a complaint regarding multiple care concerns. The scope was expanded to include resident #002.

Review of resident #002's written care plan by Inspector #601 identified the resident required staff assistance for continence care and specified interventions were in place.

Inspector #601 reviewed resident #002's Point of Care (POC) documentation for a

specified period of time and identified the PSWs did not document in POC if the resident had a bowel movement on a number of specified dates.

During separate interviews, PSW #116, RN #106, PSW #117, PSW #120, RN #102, RN #113, RPN #108, and RPN #109 indicated to Inspector #601, the PSWs should document when the resident had a bowel movement in POC.

During an interview, the Director of Care (DOC) indicated to Inspector #601 that PSWs were responsible to document when the resident had a bowel movement in POC.

The licensee failed to ensure that any action taken with respect to resident #002 under the continence care program related to documenting bowel movements, including assessments, reassessments, interventions and the resident's responses to the intervention were documented. [s. 30. (2)]

5. The licensee has failed to ensure that any action taken with respect to resident #002 under the Nutrition and Hydration program, including assessments, reassessments, interventions and the resident's responses to the intervention were documented.

Non-Compliance was identified while inspecting a complaint regarding multiple care concerns. The scope was expanded to include resident #002.

Review of resident #002's Point of Care (POC) documentation and their written care plan for eating by Inspector #601 identified the resident required specified assistance from one staff with meal and fluid intake.

Inspector #601 reviewed resident #002's POC documentation for a specified period of time identified the PSWs did not document in POC the resident's meal or fluid intake on a number of specified dates.

During separate interviews, PSW #116, PSW #120, RN #102, and RN #113 indicated to Inspector #601 the PSWs should document the resident's meal and fluid intake in Point of Care (POC).

During an interview, the Director of Care (DOC) indicated to Inspector #601 that PSWs were responsible to document the resident meal and fluid intake in POC.

The licensee failed to ensure that any action taken with respect to resident #002 under

the Nutrition and Hydration program related to documenting meal and fluid intake, including assessments, reassessments, interventions and the resident's responses to the intervention were documented. [s. 30. (2)]

6. The licensee has failed to ensure that any action taken with respect to resident #002 under the Skin and Wound Care program, including assessments, reassessments, interventions and the resident's responses to the intervention were documented.

Non-Compliance was identified while inspecting a complaint regarding multiple care concerns. The scope was expanded to include resident #002.

Review of resident #002's written care plan for impaired skin integrity by Inspector #601 identified the resident was at risk for skin breakdown due to specified reasons.

Inspector #601 reviewed resident #002's POC documentation survey report that directed staff to turn and reposition the resident every two hours and to document if the resident was turned and positioned.

Inspector #601 reviewed resident #002's POC documentation for a specified period of time and identified the PSWs did not document in POC when the resident was turned and repositioned on a number of specified dates.

During separate interviews, PSW #116, RN #106, PSW #117, Agency RN #118, PSW #120, RN #102, RN #113, RPN #108, and RPN #109 indicated the PSWs should document when the resident was turned and repositioned in Point of Care (POC).

During an interview, the Director of Care (DOC) indicated to Inspector #601 that PSWs were responsible to document when the resident was turned and repositioned in POC.

The licensee failed to ensure that any action taken with respect to resident #002 under the Skin and Wound Care programs, related to documenting when the resident was turned and repositioned, including assessments, reassessments, interventions and the resident's responses to the intervention were documented. [s. 30. (2)]

7. The licensee has failed to ensure that any action taken with respect to resident #004 under the Continence Care program, including assessments, reassessments, interventions and the resident's responses to the intervention were documented.

Non-Compliance was identified while inspecting a complaint regarding multiple care concerns. The scope was expanded to include resident #004.

Review of resident #004's 24-hour admission care planning assessment by Inspector #601 identified the resident was incontinent of bowel and bladder.

Review of the continence assessment by Inspector #601 that was completed by the Director of Care (DOC) on a specified date. The continence assessment identified that resident #004 required specified assistance from staff for continence care.

Inspector #601 reviewed resident #004's Point of Care (POC) documentation for a specified period of time and identified the PSWs did not document in POC if the resident had a bowel movement on a number of specified dates.

During separate interviews, PSW #116, RN #106, PSW #117, PSW #120, RN #102, RN #113, RPN #108, and RPN #109 indicated the PSWs should document when the resident had a bowel movement in POC.

During an interview, the Director of Care (DOC) indicated to Inspector #601 that PSWs were responsible to document when the resident had a bowel movement in POC.

The licensee failed to ensure that any action taken with respect to resident #004 under the continence care program related to documenting bowel movements, including assessments, reassessments, interventions and the resident's responses to the intervention were documented. [s. 30. (2)]

8. The licensee has failed to ensure that any action taken with respect to resident #004 under the Nutrition and Hydration program, including assessments, reassessments, interventions and the resident's responses to the intervention were documented.

Non-Compliance was identified while inspecting a complaint regarding multiple care concerns. The scope was expanded to include resident #004.

Review of resident #004's Point of Care (POC) and their 24-hour admission care planning assessment by Inspector #601 identified the resident required specified assistance from staff for meal and fluid intake.

Inspector #601 reviewed resident #004's POC documentation for a specified period of

time identified the PSWs did not document in POC the resident's meal or fluid intake on a number of specified dates.

During separate interviews, PSW #116, PSW #120, RN #102, RN #113 indicated to Inspector #601 the PSWs should document the resident's meal and fluid intake in Point of Care (POC).

During an interview, the Director of Care (DOC) indicated to Inspector #601 that PSWs were responsible to document the resident meal and fluid intake in POC.

The licensee failed to ensure that any action taken with respect to resident #004 under the Nutrition and Hydration program related to documenting meal and fluid intake, including assessments, reassessments, interventions and the resident's responses to the intervention were documented. [s. 30. (2)]

9. The licensee has failed to ensure that any action taken with respect to resident #004 under the Skin and Wound Care, including assessments, reassessments, interventions and the resident's responses to the intervention were documented.

Non-Compliance was identified while inspecting a complaint regarding multiple care concerns. The scope was expanded to include resident #004.

Review of resident #004's 24-hour care planning assessment by Inspector #601 identified the resident was admitted to the home with a specified skin impairment. The interventions included to return the resident to bed between meals and to turn and reposition the resident every two hours.

Inspector #601 reviewed resident #004's Point of Care (POC) documentation for a specified period of time and identified the PSWs did not document in POC when the resident was turned and repositioned on a number of specified dates.

During separate interviews, PSW #116, RN #106, PSW #117, Agency RN #118, PSW #120, RN #102, RN #113, RPN #108, RPN #109 indicated the PSWs should document when the resident was turned and repositioned in Point of Care (POC).

During an interview, the Director of Care (DOC) indicated to Inspector #601 that PSWs were responsible to document when the resident was turned and repositioned in POC.

The licensee failed to ensure that any action taken with respect to resident #004 under the Skin and Wound Care programs, related to documenting when the resident was turned and repositioned, including assessments, reassessments, interventions and the resident's responses to the intervention were documented. [s. 30. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that any action taken with respect to a resident under the Continence Care, Nutrition and Hydration programs and Skin and Wound Care, including assessments, reassessments, interventions and the resident's responses to the intervention are documented, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when a resident was exhibiting altered skin

integrity, including skin breakdown, specified wound, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A complaint was received by the Director on a specified date related to the management of resident #001's specified skin condition.

Review of the Skin and Wound Program: Wound Care Management policy by Inspector #601. The policy directed that when a resident exhibiting any form of altered skin integrity, which may include but is not limited to skin breakdown, unexplained bruises, pressure injuries, skin tears and wounds, will:

-Receive a skin assessment by a nurse using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. The nurse will promptly assess all residents exhibiting altered skin integrity on initial discovery. Determine if the wound is inherited or acquired, or worsening, and investigate root causes. Use clinically appropriate assessment tools, "Wound Assessment", Appendix one for pressure injuries.

Review of resident #001’s 24-hour care planning assessment by Inspector #601 identified the resident was admitted to the home with a specified skin condition.

Inspector #601 reviewed resident #001 written care plan initiated on specified date that indicated the resident had impaired skin integrity related to a specified skin condition. According to the written care plan resident #001 had specified risk factors for impaired skin integrity. The interventions included to reposition every two hours during the day and overnight; avoid laying on back; turning schedule at the bedside; monitor specified area for redness and if noted return to turning and repositioning the resident every hour.

Inspector #601 reviewed resident #001’s progress notes for a specified period of time and the following was documented:

-On a specified date and time, RN #102 documented a description of resident #001's skin condition and that a specified treatment had been applied.

-On a specified date and time, RN #113 documented a description of resident #001's skin condition and there was a specified change in the skin and the treatment being applied to the resident's specified skin condition.

Inspector #601 reviewed resident #001's Skin and Wound Assessments for their specified wound for a specified period of time and RN #113 had not completed a "Wound Assessment" for resident #001 on a specified date and time when they had identified that resident #001's specified skin condition had worsened.

During an interview, RN #113 indicated to Inspector #601 and Inspector #623 they had assessed and documented the description of the specified skin condition in the resident's progress notes. RN #113 indicated they should have been more specific with their documentation and they did not stage the resident's skin condition. RN #113 further indicated they changed the type of treatment applied to the resident's specified skin condition and did not document the treatment applied on the resident's Treatment Administration Record (TAR). RN #113 further indicated they did not complete the Skin and Wound Assessment for resident #001.

During an interview, the Director of Care (DOC) indicated to Inspector #601 that on a specified date, RN #113 had changed resident #001's treatment for their specified skin condition and they should have completed the Skin and Wound Assessment.

The licensee failed to ensure that when a resident was exhibiting altered skin integrity, including skin breakdown, specified wound, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

***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 ensure that when a resident is exhibiting altered skin integrity, including skin breakdown, specified wound, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that no drug was used by or administered to resident #001 in the home unless the drug was prescribed for the resident.

A complaint was received by the Director on a specified date related to continence care.

Inspector #601 reviewed resident #001’s Medical Directives with a specified date identified that resident #001’s physician had prescribed for resident #001 to receive a specified medication daily, as needed for elimination.

Review of resident #001's Medication Administration Record (MAR) by Inspector #601 identified that resident #001 received the specified as needed medication on a specified date with two different identified times.

Review of resident #001's progress notes by Inspector #601 identified the following was documented on the specified date:

-On a specified date and time, RN #121 documented resident #001 received the specified medication and the effectiveness of the medication was documented as not effective. On the same specified date and a different time, RPN #107 documented that resident #001 received the same specified medication and the effectiveness of the medication was documented.

During an interview, the Director of Care (DOC) indicated to Inspector #601 the physician should have been notified the specified medication given to resident #001 on the specified date and time was not effective and direction should have been obtained from the physician prior to administering the second dose of the specified medication on the

same day.

During an interview, the physician indicated to Inspector #601 and Inspector #623 that they were not made aware the resident had elimination concerns on the specified date and they did not prescribe for resident #001 to receive the second dose of the specified medication on the specified date and time.

The licensee failed to ensure that no drug was used by or administered to resident #001 in the home unless the drug was prescribed for the resident. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered according to resident #001 in accordance with the directions for use specified by the prescriber.

A complaint was received by the Director on a specified date related to continence care.

Inspector #601 reviewed resident #001’s progress notes and on a specified date and time, the NP documented that resident #001 had an identified symptoms and was likely due to an elimination problem.

Inspector #601 reviewed resident #001’s physician orders on the specified date and the Nurse Practitioner (NP) had prescribed for resident #001 to be given a specified medication on the specified date for elimination.

Inspector #601 reviewed resident #001’s Medication Administration Record (MAR) and resident #001 had not received the specified medication on the specified date, as prescribed by the NP.

During separate interview, the physician and the Nurse Practitioner indicated to Inspector #601 and Inspector #623 they were not made aware that resident #001 had not received the specified medication on the specified date, as prescribed by the NP.

During an interview, the Director of Care indicated to Inspector #601 they had discovered that resident #001 had not received the specified medication on the date the medication was prescribed by the NP.

The licensee failed to ensure that resident #001 received the specified medication on the specified date in accordance with the directions for use specified by the prescriber.

3. The licensee has failed to ensure that drugs were administered according to resident #001 in accordance with the directions for use specified by the prescriber.

A complaint was received by the Director on a specified date related to allegations of resident neglect and care concerns.

Inspector #601 reviewed resident #001's physician orders and on a specified date, the resident's physician had prescribed a specified medication for a specified medical reasons. Inspector #601 reviewed resident #001’s Medication Administration Record (MAR) and RPN #105 documented that on the specified date and time the resident did not receive their scheduled dose of the specified medication. RPN #105 documented they were not able to arouse the resident to take their prescribed specified medication.

Inspector #601 reviewed resident #001's physician orders and on a specified date, the Nurse Practitioner (NP) prescribed for resident #001 to be given a specified medication for specified medical reasons. Inspector #601 reviewed resident #001’s MAR and RPN #122 documented that on the specified date and three different identified times the resident did not receive their scheduled dose of the specified medication.

During a telephone interview, RN #121 indicated to Inspector #601 they had spoken to the complainant about the resident’s condition on a specified date. RN #121 indicated the complainant was concerned that resident #001 was not taking their oral medication and how the resident’s pain would be managed. RN #121 indicated to Inspector #601 the resident’s physician was not contacted during the night. RN #121 indicated that resident #001’s physician was not made aware that RPN #122 was not able to arouse the resident to take their prescribed medication on a specified date and time.

During an interview, the physician indicated to Inspector #601 and Inspector #623 they received a call from the nurse on a specified date. According to the physician, they were not made aware that resident #001 was not taking their routine oral medications. The physician indicated they were informed the family were concerned about the resident’s pain management due to the resident’s non-verbal cues. The physician further indicated they would have expected the resident’s routine medications would have been given.

During an interview, the Director of Care (DOC) indicated to Inspector #601 the registered staff should have collaborated with resident #001’s physician regarding the resident’s not taking their oral medication on the two specified dates.

The licensee failed to ensure that drugs were administered according to resident #001 in accordance with the directions for use specified by the prescriber.

4. The licensee has failed to ensure that drugs were administered according to the Medical Directives for resident #001's specified reason in accordance with the directions for use specified by the prescriber.

Inspector #601 reviewed the Medical Directives for resident #001's specified reason. The Medical Directives prescribed for resident #001 included three specified medications that were to be administered, as required for the specified reason on day three, day four and day five. The Medical Directives further directed to notify the physician on day five, if the specified medications were not effective.

Review of resident #001's Medication Administration Record (MAR) and Point of Care (POC) documentation related to the specified reason for a specified period by Inspector #601, identified the specified medication was not utilized for resident #001, as prescribed when the resident had the specified reason on a number of specified dates.

Review of resident #001's MAR and POC documentation related to the specified reason for a specified period by Inspector #601, identified the specified medication was not utilized for resident #001, as prescribed when the resident had the specified reason on a number of specified dates.

Review of resident #001's MAR and POC documentation related to the specified reason for a specified period by Inspector #601, identified the specified medication was not utilized for resident #001, as prescribed when the resident had the specified reason on a number of specified dates.

During an interview, RN #106, Agency RN #118, RN #104, RN #102, RN #113, RPN #108, and RPN #109 indicated to Inspector #601 that POC had an alert to inform registered staff when a resident required the specified medication. RN #106, RN #104, RN #102, RN #113, and RPN #108 indicated the evening shift should follow the Medical Directives for day three, the night shift should follow the Medical Directives for day four and if the specified medications were not effective the resident should be given a specified medication.

During an interview, the physician indicated to Inspector #601 and Inspector #623 they were not aware that resident #001 did not receive the specified medication on day three,

day four and day five as prescribed in the resident's Medical Directives for the specified reason.

The licensee failed to ensure that drugs were administered according to the Medical Directives for resident #001's specified reason in accordance with the directions for use specified by the prescriber.

5. The licensee has failed to ensure that drugs were administered according to the Medical Directives for resident #004's specified reason in accordance with the directions for use specified by the prescriber.

Non-Compliance was identified while inspecting a complaint regarding multiple care concerns. The scope was expanded to include resident #004.

Inspector #601 reviewed the Medical Directives for resident #004's specified reason. The Medical Directives prescribed for resident #004 included three specified medications that were to be administered, as required for the specified reason on day three, day four and day five. The Medical Directives further directed to notify the physician on day five, if the specified medications were not effective.

Review of resident #004's Medication Administration Record (MAR) and Point of Care (POC) documentation related to the specified reason for a specified period by Inspector #601, identified the specified medication was not utilized for resident #004, as prescribed when the resident had the specified reason on a specified date.

Review of resident #004's MAR and POC documentation related to the specified reason for a specified period by Inspector #601, identified the specified medication was not utilized for resident #004, as prescribed when the resident had the specified reason on a specified date.

During an interview, RN #106, Agency RN #118, RN #104, RN #102, RN #113, RPN #108, and RPN #109 indicated to Inspector #601 that POC had an alert to inform registered staff when a resident required the specified medication. RN #106, RN #104, RN #102, RN #113, and RPN #108 indicated the evening shift should follow the Medical Directives for day three, the night shift should follow the Medical Directives for day four and if the specified medication were not effective the resident should be given a specified medication.

During an interview, the Director of Care (DOC) indicated to Inspector #601 they were not aware that resident #004 did not receive the specified medication for the specified reason and the registered staff should have utilized the Medical Directives for resident #004, as prescribed by the physician.

The licensee failed to ensure that drugs were administered according to the Medical Directives for resident #004's specified reason in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that no drug is used by or administered to a resident in the home unless the drug is prescribed for the resident and ensure that drugs are administered according to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following:**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #001 who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and was conducted using a

clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

A complaint was received by the Director on a specified date related to allegations of staff to resident neglect regarding multiple care concerns including continence care.

Inspector #601 reviewed resident #001's 24-hour Care Planning Assessment completed on a specified date. RN #102 documented the resident's specific continence assessment. No further written interventions were documented in the 24-hour Care Planning Assessment.

Inspector #601 reviewed resident #001's written care plan related to toileting, bowel and bladder continence initiated on a specified date and the resident was identified as being incontinent of bowel and bladder.

During the inspection, Inspector #601 reviewed resident #001's Continence Assessment that had been generate in Point Click Care (PCC) the day resident #001 was admitted to the home and the assessment remained in progress. The Continence Assessment had not been completed by registered staff.

During an interview on February 27, March 4, 5, 6, 2020, RN #106, RN #104, RN #102, RN #113, RPN #108, RPN #109 indicated to Inspector #601 that a continence assessment should be completed upon admission to the home for all residents and the assessment was documented in Point Click Care (PCC), by the registered staff. RN #106, RN #104, RN #102, RN #113, RPN #108, RPN #109 indicated they had not completed the Continence Assessment for resident #001.

During an interview, the Director of Care (DOC) indicated to Inspector #601 that registered staff should have completed resident #001's Continence Assessment upon admission to the home.

The licensee failed to ensure that resident #001 who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require. [s. 51. (2) (a)]

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that either a physician or a registered nurse in the extended class, conducted a physical examination of resident #001 upon admission, and produce a written report of the findings of the examination.

A complaint was received by the Director on a specified date related to allegations of staff to resident neglect regarding multiple care concerns.

Inspector #601 completed a record review of the licensee's Attending Physician Agreement. The agreement included additional delineated services for the physician to complete a written medical history and physical examination, within seven days of the resident's admission.

Inspector #601 reviewed resident #001's written Medical Periodic Exam and the physician had completed the resident's written medical history and physical examination, on a specified date.

During an interview, the physician indicated to Inspector #601 and Inspector #623 they were not able to assess resident #001 on a specified date, the day of their admission. The physician further indicated they completed the resident's admission physical and documented the assessment, on a specified date.

During an interview, the Executive Director (ED) indicated to Inspector #601 the licensee's Attending Physician Agreement directs resident admission physicals to be completed by the physician, within seven days of the resident's admission. The ED further indicated that resident #001's admission physical was completed on a specified date and was not completed within seven days of admission, as directed in the physician agreement.

The licensee failed to ensure that resident #001's physician or a registered nurse in the extended class, conducted a physical examination of resident #001 upon admission, as resident #001's written physical examination and medial history was not completed by the physician within seven days of the resident's was admission to the home. [s. 82.]

**Issued on this 9th day of July, 2020**

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

**Original report signed by the inspector.**