Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 5, 13, 2018	2018_644507_0019	019214-17, 024623-18, 029913-18, 029998-18	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
55 John Street Metro Hall, 11th Floor TORONTO ON M5V 3C6

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

Cummer Lodge
205 Cummer Avenue NORTH YORK ON M2M 2E8

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

STELLA NG (507), MATTHEW CHIU (565), REBECCA LEUNG (726)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 5 - 7, 11 - 14, 17 - 21, 24 - 26 and 28, and October 1 - 5, 2018.

The following follow-up inspections were inspected concurrently with the RQI:
#019214-17 - CO#001 was related to prevention of abuse,
#029913-18 - CO#002 was related to transferring and positioning technique, and
#029998-18 - CO#003 was related to 24 hours admission care plan.

The following complaints were inspected concurrently with the RQI:
#004262-17 was related to Residents' Bill of Rights and plan of care,
#009390-17 was related to infection prevention and control,
#013303-17 and #023186-17 were related to staff to resident neglect and improper care of a resident,
#022068-17 was related to plan of care,
#028256-17 was related to medication administration, and
#015141-18 was related to nutrition and hydration, and bathing.

The following Critical Incident Reports (CIS) were inspected concurrently with the RQI:
#022846-17 (CIS #M512-000027-17) was related to improper care of a resident,
#001565-18 (CIS #M512-000006-18) was related to respiratory outbreak,
#005776-18 (CIS #M512-000012-18) was related to respiratory outbreak,
#005777-18 (CIS #M512-000015-18) was related to respiratory outbreak,
#005778-18 (CIS #M512-000016-18) was related to respiratory outbreak, and
#007618-18 (CIS #M512-000019-18) was related to respiratory outbreak.

Inspector Adam Dickey (643) was part of the inspection team in conducting record review on October 3, 4 and 5, 2018.

During the course of the inspection, the inspector(s) spoke with the Home Administrator, Acting Director of Care/ Nursing (A-DOC), Nurse Managers, Clinical (NM-C), Nurse Managers, Operational (NM-O), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Aides(PCA), Administration Support Assistant (ASA), Acting Support Aide (ASA), Registered Dietitian (RD), Physiotherapist (PT), Occupational Therapist (OT), Manager of Building Services (MBS), Medical Director (MD), residents, family members and substitute decision-makers (SDM).

The inspectors conducted tour of the home, observations of meal services, medication administration, staff and resident interactions, provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **6 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_493652_0004	726
O.Reg 79/10 s. 24. (2)	CO #003	2017_493652_0004	726
O.Reg 79/10 s. 36.	CO #002	2017_493652_0004	726

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) on an identified date related to multiple care areas for resident #031 and the temperature of the home.

In accordance with O. Reg. 79/10, s. 30 (1) 1, the licensee is required to ensure that there is written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Review of the home's policy titled "Temperature Monitor – Hot Water and Air", policy #BS-0705-00, section 07 – Maintenance, and publish date of February 1, 2018, stated the following:
- Maintenance staff/ Cleaner Heavy Duty/ RN-in-Charge to select random locations and record air temperature once daily at 0800 hours. In case of extreme weather condition alerts by Toronto Public Health or heating, ventilation and air conditioning (HAVC) equipment failures, record temperatures once per shift at 0800 hours, 1600 hours, and 2200 hours.

Review of the home's air temperature log did not show any records of temperature readings for two identified years.

Interview with staff #150 indicated they were unaware that the temperature readings of the home should be recorded daily according to the home??s policy. The staff member indicated when conducting the morning tour of the building, they sometimes carry the temperature monitor device and take temperature readings on different locations of the building. The staff member indicated they had never recorded the temperature on a daily basis.

Interview with staff #149 indicated the home's policy stated staff should record daily temperature using the air temperature log. Staff #149 confirmed the temperature readings of the home were not recorded as required by their policy. [s. 8. (1)]

2. In relation to intake #029913-18 a follow up inspection for Compliance Order #002 from inspection report #2017_493652_0004 was completed.

In accordance with O. Reg. 79/10, s. 30 (1) 1, the licensee is required to ensure that there is written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Review of the home's policy titled "Sling Selection and Application", policy #RC-0522-17, and publish date of November 1, 2014, stated that the conventional “Bridge” type adjustment with the leg straps crossing diagonally in front of the resident and attach to the “opposite hook” was recommended for most general transfers, safest most compatible for client.

A) Resident #007 was selected for inspection as they used a specific mobility device and required a mechanical lift for transfer.

On an identified date at an identified time, the inspector observed staff #105 and #106 transferring resident #007 from their specific mobility device to bed with a mechanical lift in the resident's room. During the transfer, the inspector observed staff #105 and #106 apply the sling for resident #007 not using the "Bridge" type method as indicated in the home's policy.

B) Resident #008 was selected as a result of non-compliance identified with resident #007. Resident #008 used a specific mobility device and required a mechanical lift for transfer.

On another identified date and at an identified time, the inspector observed staff #113 and #114 transferring resident #008 from their specific mobility device to bed with a mechanical lift in the resident's room. During the transfer, the inspector observed staff #113 and #114 apply the sling for resident #008 not using the "Bridge" type method as indicated in the home's policy.

C) Resident #009 was selected as a result of non-compliance identified with resident #007. Resident #009 used a specific mobility device and required a mechanical lift for transfer.

On the same identified date at an identified time, the inspector observed staff #115 and #116 transferring resident #009 from their specific mobility device to bed with a mechanical lift in the resident's room. During the transfer, the inspector observed staff #115 and #116 apply the sling for resident #009 not using the "Bridge" type method as indicated in the home's policy.

In an interview, staff #120 stated that staff should follow the home's "Sling Selection and Application" policy when transferring residents #007, #008 and #009 with a mechanical lift and a sling by applying the conventional "Bridge" type method. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. In relation to intake #029998-18 a follow up inspection for Compliance Order #003 from inspection report #2017_493652_0004 was completed.

The Licensee has failed to ensure that the 24-hour admission care plan developed for each resident, included any risks the resident might pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.

A) Resident #010 was selected for inspection as they had exhibited responsive behaviours prior to admission.

Review of the Warm Hand-off Form from the Behavioural Support Services Mobile Support Team on an identified date provided by the Central Local Health Integration Network (LHIN) indicated an assessment was conducted related to resident #010's behaviours. Strategies tried and recommendations were included in the report.

Review of the Behavioural Assessment Tool (BAT) dated15 weeks later provided by the Central LHIN for resident #010 identified the resident's responsive behaviours .Behaviour triggers with current interventions or interventions required were indicated in the above mentioned BAT. The BAT also stated specific intervention was initiated at the previous long term care home (LTCH) prior to the admission to the current LTCH.

Review of resident #010's 24-hour admission care plan dated six weeks later stated that the resident was identified having responsive behaviours. Further review of the above mentioned 24-hour admission care plan did not include intervention, strategy or behaviour trigger for #010's identified responsive behaviours.

In interviews, staff #118 and #119 acknowledged that the information indicated in the BAT and the Warm Hand-off Form related to resident #010's identified behaviours and the triggers, interventions, strategies and recommendations. Staff #118 and #119 stated

that the registered staff should have reviewed all pertinent information received from the Central LHIN when completing resident #010's 24-hour admission care plan. Staff #118 and #119 indicated that resident #010 continued to exhibit similar responsive behaviours since admission.

In an interview, staff #128 acknowledged that the registered staff should have reviewed the information indicated in the BAT and Warm Hand-off Form, related to resident #010's identified behaviours and triggers, interventions, strategies and recommendations; and included the pertinent information in resident #010's 24-hour admission care plan.

B) Resident #011 was selected as a result of non-compliance identified with resident #010. Resident #011 had exhibited responsive behaviours prior to admission.

Review of the BAT on an identified date provided by the Central LHIN indicated that resident #011 had responsive behaviours. Behaviour triggers with current interventions or interventions required were included in the above mentioned BAT.

Review of the Physical. Intellectual. Emotional. Capabilities. Environment. Social (P.I.E.C.E.S.)/ Functional Assessment one week later provided by the Central LHIN indicated that resident #011 was assessed and the resident's responsive behaviours were identified. The behaviour assessments, strategies tried with recommendations for the resident's behaviour management were included in the report.

Review of resident #011's 24-hour admission care plan completed six weeks later indicated that the resident was identified as having responsive behaviours. Further review of resident #011's 24-hour admission care plan did not include any interventions for managing the resident's responsive behaviours.

In interviews, staff #118 and #119 stated that the pertinent information indicated in resident #011's BAT and P.I.E.C.E.S./ Functional Assessment was not included in resident #011's 24-hour admission care plan. Staff #118 and #119 indicated that resident #011 continued to exhibit similar responsive behaviours since admission. Both staff acknowledged that registered staff should have reviewed the information indicated in the BAT and P.I.E.C.E.S./ Functional Assessment related to resident #011's identified behaviours and the triggers/ interventions/ strategies and recommendations and included them in resident #011's 24-hour admission care plan as appropriate.

C) Resident #012 was selected as a result of non-compliance identified with resident

#010. Resident #012 had exhibited responsive behaviours prior to admission.

Review of the BAT on an identified date provided by the Central LHIN indicated that resident #012 had responsive behaviours. Behaviour triggers with current interventions or interventions required were included in the BAT.

Review of the P.I.E.C.E.S./ Functional Assessment dated one month later provided by the Central LHIN indicated that resident #012 was assessed and the resident's responsive behaviours were identified. Behaviour assessment, strategies tried with recommendations were included in the report.

Review of resident #012's 24-hour admission care plan completed three weeks later indicated that the resident was identified having responsive behaviours. Further review of resident #012's 24-hour admission care plan did not include any intervention/ strategy/ trigger in managing the resident's responsive behaviours.

In interviews, staff #118 and #119 stated that the pertinent information indicated in resident #012's BAT and P.I.E.C.E.S./ Functional Assessment was not included in resident #012's 24-hour admission care plan. Both staff indicated that resident #012 continued to exhibit similar responsive behaviours since admission. Both staff acknowledged that registered staff should have reviewed the information indicated in the BAT and P.I.E.C.E.S./ Functional Assessment related to resident #012's identified behaviours and the triggers/ interventions/ strategies and recommendations, and included the information in resident #012's 24-hour admission care plan as appropriate. [s. 24. (2) 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 to ensure that the 24-hour admission care plan developed for each resident, includes any risks the resident may post to others, including any potential behavioural triggers, and safety measures to mitigate those risks, to be implemented voluntarily.

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 actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

A) A complaint was received by the MOHLTC on an identified date in regard to resident #023's nutrition and hydration, and bathing.

Review of the home's policy titled, "Nursing and Personal Care Record - Food and Fluid Intake", policy #NU-0211-04, with publish date July, 2013, stated that residents' intake for food and fluid would be documented on the Nursing and Personal Care Record (NPCR) immediately after consumption. The policy further stated that registered staff would document resident's meal, fluid and supplement intake if taken at mealtime, on the NPCR for food and fluid intake immediately after each meal service. Personal care staff would document snack, food, fluid and supplement intake on the NPCR for food and fluid intake immediately after resident's intake. The NPCR for food and fluid intake template was attached to the policy indicated the following were to be documented daily:
- Meal (breakfast, lunch and dinner) - meal taken-all, between ½ and ¾ meal take, between ¼ and ½ meal taken or did not eat
- Fluids at meal time (breakfast, lunch and dinner) - all fluids taken at meals, more than ½ fluids taken at meal, less than ½ fluids taken at meal or did not drink
- Snacks (morning, afternoon and bedtime) - snacks taken - all, more than ½ snack taken, less than ½ snack taken or did not eat
- Fluids at snack time - all fluids taken at snack time, more than ½ fluids taken at snack time, less than ½ fluids taken at snack time or did not drink.

In an interview, resident #023's Substitute Decision-Maker (SDM) stated that staff did not

provide assistance to resident #023 when the resident refused to eat or bathe.

Record review of resident #023's most recent written plan of care on an identified date included interventions for the resident's eating.

In interviews, staff #129, #130 and #136 stated that resident #023 required assistance at meal times.

On multiple occasions, the inspector observed resident #023 received assistance at meal times.

Record review of the Nursing and Personal Care Record (NPCR) for Food and Fluid intake for an identified three months period for resident #023 indicated that a total of 14 days, documentation were not completed for all meal/ snack services for the day.

In an interview, staff #123 stated registered staff were to document a resident's food and fluids intake at meal times, and personal care staff were to document a resident's snack and fluids intake at snack times. Staff #123 acknowledged the above mentioned meals, snacks and fluids were not documented immediately after resident #023's intake, and stated staff should document the resident's food and intake after every meal and snack as required.

B) Resident #025 was selected as a result of non-compliance identified with resident #023.

Record review of the NPCR for Food and Fluid intake for an identified three months period for resident #025 indicated that a total of 90 days, documentation were not completed for all meal/ snack services for the day.

In an interview, Staff #123 stated registered staff were to document a resident's food and fluids intake at meal times, and personal care staff were to document a resident's snack and fluids intake at snack times. Staff #123 acknowledged the above mentioned meals, snacks and fluids were not documented immediately after resident #025's intake, and stated staff should document the resident's food and intake after every meal and snack as required.

C) Resident #004 was selected as a result of non-compliance identified with resident #023.

Record review of the NPCR for Food and Fluid intake for an identified three months period for resident #004 indicated that a total of 84 days, documentation were not completed for all meal/ snack services for the day.

In an interview, staff #123 stated registered staff were to document a resident's food and fluids intake at meal times, and personal care staff were to document a resident's snack and fluids intake at snack times. Staff #123 acknowledged the above mentioned meals, snacks and fluids were not documented immediately after resident #004's intake, and stated staff should document the resident's food and intake after every meal and snack as required. [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 to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Resident #005 was triggered for altered skin integrity during stage one of the RQI.

Record review of the health record for resident #005 indicated that the resident developed an altered skin integrity in an identified month.

Record review of the weekly ulcer/ wound assessment record for resident #005 from the above mentioned identified month, for a period of six months, showed that the skin assessments for the resident's altered skin integrity were completed on 12 identified dates.

In interviews, staff #125 and #128 stated that registered staff were responsible for completing the weekly skin assessments using the weekly ulcer/ wound assessment record for residents who had altered skin integrity. Staff #125 and #128 confirmed that weekly skin assessments were not completed for resident #005's altered skin integrity for the above mentioned six months period.

B) Resident #004 was triggered for altered skin integrity during stage one of the RQI.

Record review of the health record for resident #004 indicated that the resident was admitted to the home on an identified date, and the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) completed the next day indicated the resident had an altered skin integrity. Record review of the most recent RAI-MDS completed nine months later for resident #004 indicated that the resident had an altered skin integrity.

Record review of the weekly ulcer/ wound assessment record for resident #004 for a six months period up to the most recent completion date of the RAI-MDS showed that the skin assessments for the resident's altered skin integrity were not completed on three identified dates.

In interviews, staff #121 and #123 stated that registered staff were responsible for completing the weekly skin assessments using the weekly ulcer/ wound assessment record for residents who had altered skin integrity. Staff #121 and #123 confirmed that weekly skin assessments were not completed on the above mentioned three identified dates for resident #004's altered skin integrity. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

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

Findings/Faits saillants :

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

A complaint was received by the MOHLTC on an identified date in regard to resident #024's medication administration.

In an interview, resident #024's SDM stated that they were concerned of medication administration for resident #024.

Record review of the health record for resident #024 indicated that the resident admitted to the home on an identified date with identified diagnoses.

Record review of the physician's order for resident #024 on an identified date stated to give the resident an identified medication with specific dosage, specific route (route A) and specific frequency for specific state of the resident. Further review of the physician's order for resident #024 dated the day after stated to try the above mentioned identified medication with a different specific dosage, specific route (route B) and specific frequency prior to trying the route A dose.

Record review of the Medication Administration Record (MAR) for a two months period for resident #024 indicated the resident was prescribed the above mentioned identified medication with specific dosage, specific route (route B) and specific frequency when needed before giving the same medication by route A. The same MAR also indicated the resident was prescribed the same identified medication with specific dosage with specific route (route A) with specific frequency as needed for a specific state of the resident.

Record review of the progress notes for the first month of the above mentioned two months period for resident #024 indicated that the resident exhibited responsive behaviours. This was confirmed by staff #155 during an interview.

Record review of the above mentioned MAR showed that resident #024 received the above mentioned specific medication by route A on three identified dates and identified times without receiving the same identified medication by route B prior.

In an interview, staff #155 stated that at the time of the above three mentioned dates, resident #024 exhibited responsive behaviours. Staff #155 administered the above

mentioned identified medication by route A to resident #024 without realizing the resident was prescribed the same medication by route B prior to administering the medication by route A on the above mentioned dates and times. [s. 131. (2)]

2. A complaint was received by the MOHLTC on an identified date related to a specific health condition monitoring for resident #052.

In an interview, resident #052's SDM stated the team had discussed the option of changing resident #052's medication for the above mentioned specific health condition. Resident #052's SDM declined the option as they were afraid that resident #052's specific health condition might be negatively impacted.

Review of the health record for resident #052 indicated the resident was admitted to the home on an identified date for a specific period.

In an interview, staff #160 indicated that registered staff initiated specific monitoring at specific frequency for resident #052 after admission for monitoring of their specific health condition.

Review of the specific health condition monitoring record and progress notes for the period that resident #052 was admitted to the home indicated that resident #052's specific monitoring readings ranged from an identified reading to another identified reading with no sign or symptom of negative impact on the specific health condition when assessed by the registered staff.

Review of original physician order dated the same day resident #052 was admitted to the home indicated that resident #052 was prescribed by the physician to have an identified medication for the specific health condition at a specific time according to the specific monitoring at the specific time. Review of the medication incident report dated three days after resident #052's admission indicated that the registered staff worked on that day administered the above mentioned specific medication to resident #052 at an identified time, not the specific time as indicated in the original physician order. No adverse reaction was documented on file.

The registered staff involved indicated in the incident report that they gave the above mentioned specific medication according to the Medication Administration Record (MAR) and the order was transcribed in a wrong way. As a result of this medication error, resident #052 received an extra dose of the specific medication. The on-call physician

and the SDM were notified regarding the incident.

The registered staff administered the extra dose of the above mentioned specific medication to resident #052 on the above mentioned identified date at an identified time was not available for interview.

In an interview, staff #128 acknowledged that the registered staff did not administer the specific medication to resident #052 in accordance with the directions for use specified by the physician. [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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A complaint was received by the MOHLTC on an identified date related to multiple care areas for resident #031.

Review of resident #031's plan of care and RAI-MDS assessment revealed the resident required assistance for bed mobility and repositioning. The plan of care further stated resident #031 required a specific therapeutic nutritional intervention scheduled daily for a specific period of time. When the resident was in bed, during specific therapeutic nutritional intervention and at least 30 minutes after the intervention, the head of the bed should be in an specific position. The plan of care did not mention the positioning of the resident in bed when they were not receiving the specific therapeutic nutritional intervention.

Review of a hospital consultation record revealed on an identified date, resident #031 had a specific diagnose and a specific position would improve the resident's specific identified health condition.

Observation conducted on an identified date at an identified time indicated when resident #031 was not receiving the specific therapeutic nutritional intervention in bed, the head of bed was placed in a specific position and the resident was awake.

Interviews with staff #121, #138, #139 and #146, indicated they always kept the resident's head of bed in a specific position at night time, and they could not let the resident sleep in other positions. Staff #121, #139 and #146 further stated it was because of the resident's specific health condition. Staff #121 and #146 confirmed the resident's positioning in bed while not receiving the specific therapeutic nutritional intervention was not included in the written plan of care.

Interview with staff #123 indicated that according to the above mentioned hospital consultation record and their risk for a specific condition, the resident's head of bed should be placed in a specific position when they were in bed while not receiving the specific therapeutic nutritional intervention. Staff #123 further stated this was the care that the resident had been receiving. Staff #123 confirmed the planned care was not included in the written plan of care prior to it was brought to staff's attention during staff interview. [s. 6. (1) (a)]

Issued on this 14th day of November, 2018

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

Original report signed by the inspector.