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

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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
Dec 5, 2018	2018_643111_0017	019219-18	Resident Quality Inspection

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

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

LYNDA BROWN (111), CHANTAL LAFRENIERE (194)

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): August 20 to 24, 2018 and August 27 to 30, 2018

The following critical incidents were completed concurrently during this RQI:
-Log # 024250-17 (CIR) and Log # 004004-18 (for CIR) for alleged resident to resident abuse
-Log # 002729-18 (CIR), Log # 004990-18 (CIR) and Log # 014133-18 (CIR) related to falls with injury
-Log # 012292-18 (CIR), Log # 006373-18 and Log # 000738-18 related to outbreaks

The following complaints were also completed concurrently during this RQI:
-Log # 018948-17 related to falls and continence/bowel management
-Log # 025425-17 related to low lighting
-Log # 005138-18 and Log # 013973-18 related to falls and improper care

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist, Resident Council President, Family Council President, residents, families, maintenance staff, Registered Dietitian (RD), RAI Coordinator and BSO staff.

During the course of the inspection, the inspector(s): completed a tour of the home, reviewed medication incidents, reviewed health care records of current and deceased residents, reviewed resident and family council meeting minutes and reviewed the following licensee policies: Pain Identification and Management, Falls Management, Continence Care and Zero Tolerance of Abuse and Neglect.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **8 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

s. 6. (5) 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 opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee has failed to ensure that the resident, the SDM if any, and the designate of the resident/ SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

Related to Log #013973-18 and #014133-18:

A complaint was received by the Director from the family of resident #023 regarding failing to call the Substitute Decision Maker (SDM) immediately with any resident concerns and resident #023 had sustained three falls in the home (on specified dates) and the SDM was not immediately notified to participate in actions to be taken.

Review of the health record for resident #023 indicated the resident was no longer in the home. Review of the progress notes for resident #023 indicated the resident sustained three falls as per the following:
-the first fall occurred on a specified date and time and after the fall, the resident complained of pain to a specified area and was given a pain medication. The following day, the resident continued to complain of pain to the specified area and was guarding the area. The resident was given another pain medication for pain. There was no indication the SDM was notified of the fall the previous evening or the resident's change

in condition (continued complaints of pain to a specified area). The resident went on a leave of absence (LOA) with the SDM for a specified period of time. The resident continued to complain of pain to the specified area upon return form the LOA. The SDM reported the resident had complained of pain to the specified area during the LOA. The SDM was still unaware that a fall had occurred resulting in pain to the specified area.
-the second fall occurred on a specified date and time (the following month) and RN #109 indicated the resident sustained a fall in the bathroom. No injuries or pain noted. The RN indicated the SDM was to be notified at a later time but there was no indication the SDM was notified.
-approximately two days later, the SDM was visiting the resident when the resident's room mate informed the SDM the resident had sustained a fall two days earlier. The registered staff confirmed the SDM was not informed of the fall the previous month or the fall two days prior. The SDM reminded staff to notify the SDM at any time. Staff indicated they were unable to document the SDM's request.
-five months later, the SDM reminded staff again to contact the SDM at any time with any changes in the residents condition.
-four days later (CIR) at specified time, RN #120 indicated the resident sustained a fall from the bed and complained of pain to a specified area. The resident was returned to bed and pain medication was given. Approximately five hours later, RN #120 indicated the resident continued to complain pain to the specified area but no indication pain medication was given. Approximately one hour later, RN #120 indicated the resident was suspected of an injury to a specified area due to increased complaints of pain to the specified area and the resident was transferred to hospital for assessment. The SDM was contacted at that time. The SDM was notified at that time. The Medical Director reported the resident sustained an injury to a specified area and would return to the home for comfort care. The resident passed away the following evening.

Interview with RN #120 by Inspector #11, indicated awareness of fall with resident #023 but was unable to recall what time the fall occurred. The RN indicated the resident only complained of slight pain in a specified area and gave the resident a pain medication. The RN indicated later in their shift, the resident was complaining of increased pain to the specified area. The RN indicated 911 was called and at that time the SDM was also notified of the fall and transfer to hospital. The RN indicated the SDM was not notified of the fall at the time of the fall. The RN indicated the SDM was not immediately informed about the fall.

Interview with the DOC by Inspector #111, indicated the expectation is that all registered nursing staff are to notify the SDMs of any falls or change in resident's condition

immediately, unless the family specifically request not to be called.

The licensee failed to ensure the SDM of resident #023 had been provided the opportunity to participate fully in the development and implementation of the plan of care. The SDM of resident #023 was not informed of a fall that occurred on a specified date until approximately one month later. The SDM was not informed of a second fall that occurred on a specified date until two days later when the SDM was informed of the fall by a co-resident. The SDM was also not informed of a third fall that occurred on on a specified date and time until a number of hours later, when the resident was being transferred to hospital for assessment.[s. 6. (5)]

2. The licensee has failed to ensure that the care set out in the plan of care, was provided to the resident as specified in the plan.

Related to Log #005138-18 and #004990-18:

Review of the progress notes for resident #022 indicated on a specified date, the physician assessed the resident for new complaints of pain to specified areas that was reported to the RN earlier the same day. The physician indicated the resident's specified vital signs were abnormal and the resident was complaining of pain to a specified area, and suspected a specified diagnosis. The physician notified the SDM of the assessment, orders for specified diagnostic tests, additional pain medication and the SDM agreed.

Review of the physician orders for resident #022 indicated on a specified date, specified diagnostic tests were ordered and a routine pain medication. The order for pain medication was processed as ordered but there was no documented evidence in the resident's health record the diagnostic tests were completed as ordered.

Interview with RN #103 by Inspector #111, confirmed awareness of a physician order for resident #022 for specified diagnostic tests but could not indicate why the tests were not completed as ordered.

Interview with DOC by Inspector #111, confirmed there was no documented evidence that the diagnostic tests that were ordered for resident #022 on a specified date were completed. The DOC indicated the hospital was contacted where the diagnostic tests would have been completed and they also confirmed the diagnostic tests were never completed.

The licensee failed to ensure the planned care for resident #022 (diagnostic tests) that were ordered by the physician, were provided to the resident. [s. 6. (7)]

3. The licensee has failed to ensure that when the resident was being reassessed, the plan of care was revised because care set out in the plan had not been effective and different approaches had been considered in the revision of the plan of care.

Related to Log #002729-18:

A critical incident report (CIR) was submitted to the Director on a specified date for a fall that resulted in transfer to hospital and significant change in condition. The CIR indicated on a specified date and time, resident #024 was being transferred in a mobility aid by PSW #121 when the resident sustained a fall, sustaining an injury to a specified area. The resident was transferred to hospital and returned to the home for comfort care. The resident passed away the following day. The CIR indicated this was the resident's second fall in a specified period of time.

Review of the health care record for resident #024 indicated the resident had only been in the home for a short period of time. The progress notes indicated during that time, the resident had sustained multiple falls. After the second last fall, the DOC noted the resident had sustained multiple falls, identified possible causes and to order specified fall protective equipment. After the last fall (CIR), an alarming device and one to one monitoring was implemented. The resident died approximately two weeks later.

Review of the written plan of care for resident #024 indicated the resident was at risk for falls. There were specified interventions identified on admission. Additional specified interventions were not considered until after the last fall.

During an interview with the DOC by Inspector #111, the DOC confirmed that resident #024 was a high risk for falls and had sustained multiple falls over a short period of time in the home. The DOC confirmed resident #024 had not been discussed at the falls prevention meeting because the resident had been admitted after one meeting and had passed away before the next meeting. The DOC confirmed that additional interventions were not considered until after multiple falls had already occurred.

The licensee had failed to ensure that when resident #024 was being reassessed after each fall, the plan of care was revised when the care set out in the plan had not been effective and different approaches had been considered in the revision of the plan of

care, as different approaches were not considered until after multiple falls. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that 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 is complied with.

Under O.Reg.79/10, s.52 (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.
2. Strategies to manage pain, including non-pharmacological interventions, equipment, supplies, devices and assistive aids.
3. Comfort care measures
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.
(2)Every licensee of a Long-Term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate

assessment instrument specifically designed for this purpose.

Review of the licensee's Pain Identification and Management policy (RC-19-01-01) revised February 2017 indicated:
-on page 1, 2/5, assess residents for pain using the Pain Flow Note in PCC (if resident is non-verbal or cognitively impaired, use the PAINAD). A pain flow note will be completed on all residents who meet any of the following criteria: resident states they have pain, any change in condition that has the potential to impact the resident pain level, new diagnosis of painful disease, taking new pain-related medication for less than 72 hours, taking an increased dose and/or frequency of pain-related medications, distress as observed through facial grimacing, guarding, or holding an area of the body, etc.
-on page 3/5, notify the physician of the residents pain including the analysis of the assessments if the resident reports sudden onset of new pain or worsening pain or when the resident consistently reports pain for 24 hours, complete referrals to other internal/external disciplines such as physiotherapy or massage therapy and/or external pain specialist as appropriate; assess the effectiveness of pain control strategies pre and post intervention and determine if the effect of the intervention meets the residents goal for pain management or if pain requires further adjustment; update the resident's care plan to reflect pain management strategies.

A. Related to Log #005138-18 and #004990-18:

Log #005138-18:
A complaint was received from a family member for resident #022 regarding the resident having a significant change in condition following a medication incident and regarding a fall.

Log #004990-18:
A critical incident report (CIS) was submitted to the Director on a specified date, for a fall that occurred on a specified date and time, that resulted in transfer to hospital and a significant change in condition. The CIS indicated the resident sustained an injury to a specified area as a result. The CIS was amended and indicated the resident passed away two days later.

Review of the progress notes for resident #022 indicated:
- On a specified date and time, the resident reported new complaints of pain to specified areas to RN #103. No pain medication was given. The physician later assessed the resident for new complaints of pain and ordered a new pain medication. Later the same

day, the resident continued to complain of pain to the specified area and the pain medication was started at that time. The resident continued to complain of pain to the specified area, despite the use of the new pain medication. Later that same day, RN #125 indicated the resident continued to complain of pain to the specified area and to monitor for need for stronger pain medication but no pain medication was offered at that time.
-On a specified date and time, RN #103 indicated the resident continued to have complaints of pain in a specified area. The RN notified the physician and new medications were ordered.
-The following day, an RN indicated the resident continued to complain of pain to specified area, the physician was contacted and ordered one of the new pain medications were ordered held for a specified period. The following day, at a specified time, the resident appeared in discomfort and with a significant change in condition. A medication was given with good effect, but still uncomfortable and the SDM was notified. The SDM agreed to keep the resident in the home on comfort measures. The RN contacted the physician and additional pain medications were ordered for comfort care. The following day, the resident continued to have visible signs of discomfort and a pain assessment was completed at that time. Two days later, the resident subsequently died.

Review of the written plan of care (in place at that time) for resident #022 indicated no planned care related to new diagnosis of painful disease, ongoing complaints of pain to specified areas, palliative care, new pain medications ordered and the resident sustaining a fall resulting in pain to a specified area.

Review of the electronic pain assessments for resident #022 indicated a pain assessment was completed on a specified date and time and the resident's pain level was low but the rest of the pain assessment was incomplete. The next pain assessment was completed the following day and indicated the residents pain level was high, indicated the location of the pain, what caused the pain and the pain was constant. There were no other pain assessments documented despite the resident developing new pain to a specified area on a specified date and receiving a new pain medication. There was no pain assessment completed when the resident developed a different pain on two separate dates and had a medication ordered. There was no pain assessment completed when the resident was also started on new pain medication on a specified date, and which was later increased two days later.

During an interview with RN #103 by Inspector #111, the RN indicated, when a residents health condition starts to deteriorate, they would contact the family for wishes, and then

contact the physician to receive orders for end of life. The RN indicated they would complete the Palliative Care Physician Order Set form. The RN indicated the care plan would be updated to reflect palliative care status and also complete the Palliative Performance Scale (PPS) for pain relief on PCC. The RN confirmed that no pain assessment was completed for resident #022 until the resident was ordered end of life pain medications, despite new complaints of pain, and pain after sustaining a fall. The RN confirmed they were working when a medication incident involving resident #022 occurred, the physician was notified with new orders and confirmed the order was not transcribed. The RN indicated they were also working on an identified date, when resident #022 had a significant change in condition. The RN indicated they contacted the SDM to update on the residents condition and confirmed they should have called the physician first for direction on whether to send the resident to the hospital or call 911. The RN indicated that on specified date and time, the RN received in report that resident #022 was having pain. The RN indicated when the PSW's went to provide care to the resident, they requested the RN come to assess the resident for complaints of pain to a specified area. The RN indicated they immediately went to assess the resident and noted possible injury to a specified area, called 911 and also notified the SDM. The RN confirmed no pain assessment was completed for any of the incidents.

During an interview with the DOC by Inspector #111, the DOC indicated, the expectation is that all registered nursing staff are to complete a pain assessment for all residents with a change in condition resulting in pain and offer the resident pain medication as appropriate. The DOC indicated the expectation was that registered nursing staff are to notify the physician with any change in the resident's condition resulting in new pain or ongoing pain that is not relieved with pain medication provided. The DOC indicated the resident`s plan of care is to be updated to include pain and interventions to manage the pain. The DOC confirmed resident #022 did not have appropriate pain flow notes and pain assessment tool completed, the physician was not notified when the resident had new pain and the residents care plan was not updated.

B. Related to Log #013973-18 and #014133-18:

Review of the health record for resident #023 indicated the resident had sustained a fall on a specified date, which resulted in ongoing pain to a specified area. The resident also sustained a change in health status with a new painful diagnosis and another fall on a specified date, resulting in pain. The resident died on a specified area. The resident had complaints of pain and there was no indication the pain policy was complied with as follows:

-on a specified date and time, an RN indicated the resident sustained a fall but no injuries or pain noted at that time. At a specified time, the resident complained of pain to a specified area and was given a pain medication. There was no pain flow note completed, the physician was not notified of the fall with new pain and there was no post assessment from the next shift to determine if the analgesic was effective in managing the residents pain, as per the policy. The following day, at a specified time, the resident continued to complain of pain to the specified area and there was no indication the resident was given any pain medication until a number of hours later, when the resident was given another pain medication. There was no indication a pain flow note was completed, the resident was assessed post administration of analgesic on the next shift to determine effectiveness, or to indicate the physician was notified as per the policy. The following day and at a specified time, the resident continued to complain of pain to the specified area. There was no indication pain medication was offered, a pain assessment was completed and no indication the physician was notified as per the policy. The resident then went on a leave of absence (LOA) with the SDM.
-on a specified date and time, the resident continued to complain of pain to the specified area, indicated the pain had been ongoing and was getting worse. The SDM reported the resident's pain was first noticed by the SDM when going out on the LOA and a note was left for the physician to assess. There was no indication the resident was offered any pain medication despite complaining of pain to a specified area and was getting worse, there was no documented evidence a pain flow note was completed or the plan of care updated related to new pain as per the policy. On a specified date and time, the resident was assessed by the physician for ongoing complaints of pain to a specified area and indicated the resident reported the pain to specified area for a few days and resident unable to recall falling. The physician was unaware that a fall had occurred and the resident had ongoing complaints of pain to a specified area that was getting worse since the fall. There was no documented evidence the resident was offered pain medication, a pain flow note was completed and no indication the resident`s care plan was updated as per the policy.
-on a specified date and time, the physician discussed the residents deteriorating condition with the SDM and comfort care was ordered. A pain assessment was completed at this time but no indication the resident`s care plan was updated as per the policy.
-on a specified date and time (CIR), RN #120 indicated the resident sustained a fall from bed. The resident complained of pain to specified areas, hourly checks to be completed and a specified pain medication was given. There was no indication a pain flow note was completed to determine the effectiveness of the pain medication and there was no indication on the electronic Medication Administration Record of the pain medication

given to indicate time and dose given. Later in the shift, the RN indicated the resident complained of “some tenderness" to a specified area but no indication pain medication was offered. An hour later, RN #120 indicated the resident had been favoring a specified area during most of the shift, complaining of increased pain, unable to move easily. 911 was called and the resident was transferred to hospital at that time. The Medical Director reported the resident sustained an injury to a specified area and would return to the home for palliative care. New pain medications were ordered and the resident subsequently passed away.

Review of the electronic Medication Administrator Records for specified dates, for resident #023 indicated, despite the resident having ongoing complaints of pain to a specified area, received prn narcotic analgesic as follows:
-during the first month, received the pain medication on two separate dates and times.
-during the second month, received the pain medication on five separate dates and times.
-after a subsequent fall, there was no indication the resident received PRN pain medication despite complaints of severe pain to a specified area.

During an interview with RN #120 by Inspector #111, the RN indicated, awareness of fall with resident #023 on a specified date, but was unable to recall what time the fall occurred. The RN indicated the resident only complained of slight pain to a specified area at time of the fall and gave the resident pain medication that was effective. The RN could not recall how much pain medication was given, what time the medication was given, why there was no documented evidence of the pain medication being given or no documentation of the effectiveness of the pain medication. The RN indicated later in the shift, the PSWs reported the resident was complaining of severe pain to a specified area. The RN indicated the resident was assessed, noted the resident was in severe pain to the specified area. The RN indicated 911 was called and the resident was transferred to hospital for assessment. The RN could not indicate why the resident was not offered any pain medication at that time, despite complaints of severe pain to the specified area. The RN confirmed a pain assessment was not completed as per the policy. The RN indicated PSW#117 and #121 were also working when the fall occurred.

During an interview with PSW #121 by Inspector #111, the PSW indicated, awareness of resident #023 sustaining a fall on a specified date and time, as the PSW initially responded to the fall. The PSW indicated that the resident complained of pain to specified areas at the time of the fall. The PSW indicated they assumed the RN was assessing the resident hourly post fall, as per the policy. The PSW indicated later in the

shift, PSW #117 and #121 went to provide toileting to resident #023, the resident was in increased pain and unable to move a specified area. The PSW indicated they notified the RN immediately.

During an interview with PSW #117 by Inspector #111, the PSW indicated, awareness of resident #023 sustaining a fall on a specified date and time. The PSW was not present when the fall occurred and indicated that PSW #121 and RN #120 responded to the fall. The PSW indicated they usually check and/or toilet the residents twice a shift. The PSW indicated when they started their last check (at a specified time), they could hear resident #023 screaming out in pain. The PSW indicated they immediately went into the resident's room and the resident was unable to move due the increased complaints of pain. The PSW indicated RN #120 was immediately notified.

During an interview with the DOC by Inspector #111, the DOC indicated the expectation is that all registered nursing staff are to complete a pain assessment for all residents with a change in condition resulting in pain and offer the resident analgesic as appropriate. The DOC indicated the expectation was that registered nursing staff are to notify the physician with any change in the resident's condition resulting in new pain or ongoing pain that is not relieved with pain medication provided. The DOC indicated the resident`s plan of care is to be updated to include pain and interventions to manage the pain. The DOC confirmed resident #023 did not have appropriate pain flow notes completed, appropriate pain assessment tool completed, the physician notified when the resident sustained a fall with ongoing pain to a specified area until a month later, and the residents care plan was not updated.

The licensee failed to ensure the Pain Identification and Management policy was complied with, as resident #023 had ongoing complaints of pain to a specified area (post fall) for a specified period of time and the physician was not informed of the fall with new pain or ongoing pain. No pain assessment was completed during that time and the care plan was not updated to reflect the new pain. On a specified date, when the resident had a new painful diagnosis, the care plan was not updated. On a specified date, when the resident sustained a fall with new pain to a specified area, was not given analgesic and was also not given analgesic when the pain level increased. [s. 8. (1) (a) (b)]

2. Under O.Reg. 79/10, s. 51(1)The continence care and bowel management program must, at a minimum, provide for the following:
(2) (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.

Review of the licensee "Continence Management Program" policy # RC 14-01-01 dated February 2017 was completed by inspector #194 and indicated:
-complete a continence assessment using a clinically appropriate assessment tool that is specifically designed for assessing continence. An assessment is completed with any deterioration in continence level.

An interview with RN #103 was completed by Inspector #194, related to continence assessment being used at the home. RN #103 provided a copy of the electronic "Continence Assessment –V3" and stated that the home used a "quick reference" sheet located at the nursing station which is laminated indicating that continence assessments, that a "3 day elimination monitoring tool" is also to be completed with a change in the resident's continence status.

An interview with RAI Coordinator #105 was conducted by Inspector #194, related to completion of continence assessments for residents in the home. The RAI Coordinator indicated that the continence assessments for residents in the home were to be completed by the registered staff on the unit.

A. During stage 1 of the RQI, worsening incontinence for resident #018 was triggered in MDS.

Resident #018 ambulated independently with use of mobility aid and required extensive assistance from one staff for activities of daily living (ADL).

Review of MDS related to continence on a specified date, indicated that resident #018 was continent of bowel and frequently incontinent of bladder. The next quarter MDS related to continence indicated resident #018 was frequently incontinent of bowel and bladder.

An interview with PSW #104 was conducted by Inspector #194 related to continence status for resident #018. PSW #104 verified that resident #018 had a change in continence status over an identified period related to increase pain in the resident's feet resulting in a decrease in mobility for the resident.

An interview with RN #103 was conducted by Inspector #194, related to continence status for resident #018 during a four month period. RN #103 indicated being aware that resident #018 had a change in continence status. Inspector #194 and RN #103 reviewed the clinical health record for resident #018 with no evidence of a continence assessment being completed for that period of time when a change in continence status was indicated in MDS.

B. During stage 1 of the RQI, worsening incontinence for resident #007 was triggered in MDS.

Review of the MDS assessment related to continence on specified date, indicated that resident #007 was continent of bowel, the following MDS assessment indicated resident #007 to be occasionally incontinent of bowel and on a subsequent MDS assessment, indicated that resident #007 was now frequently incontinent of bowel.

Resident #007 is dependent on staff for mobility and ADL.

During interview with Inspector #194, RN #113 indicated that during a specified date, resident #007 was suffering with constipation issues. RN #113 explained that resident #007's mobility had decreased during this period.

During interview with Inspector #194, PSW #110 indicated that resident #007's bowel continence during a specified period had declined. PSW #110 indicated that resident #007 had an increase in incontinence related to the resident's inability to consistently call staff for assistance to the bathroom.

Review of the clinical health record for resident #007 was completed with no evidence of a Continence assessment being completed when MDS assessments indicated a changed in continence status for the resident.

C. Review of the MDS assessment related to continence on a specified date, indicated that resident #021 was occasionally incontinent of bowel and frequently incontinent of bladder. The following quarterly MDS assessment indicated that resident #021 was continent of bowel and frequently incontinent of bladder.

Resident #021 is independent with ambulation but required assistance from one staff for transferring and ADL.

An interview with PSW #111 indicated a change in resident #021's continence status had been noted during a specified period of time. PSW #111 described resident #21 as being independent with mobility and toileting, relying on a co-resident in the home for assistance. PSW #111 indicated that resident #021 had been independent with continence and not a reliable source for bowel movements. PSW #111 indicated that after the resident #021 sustained an injury to a specified area, the resident was more dependent on staff for toileting and bowel movements were more easily monitored.

RN #113 indicated that resident #021 was noted to have a change in status during this period related to concerns with a specified area and staff were trying to keep bowels soft to relieve any pain. RN #113 indicated that resident #021 did have a general decline in health status during this period but was not aware of any changes in continence status for the resident.

Review of the clinical health record for resident #021 was completed with no evidence of a Continence assessment being completed when MDS assessments specific to continence on two specified dates indicated a change in continence status for the resident.

The licensee failed to ensure the Continence Management Program (policy # RC 14-01-01 dated February 2017) was complied with for resident #007, #018 and #021 as there was no continence assessment completed using a clinically appropriate assessment tool that is specifically designed for assessing continence, when the resident's had any deterioration in continence level.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The licensee failed to ensure that steps are taken to minimize the risk of altercation and potentially harmful interactions between resident #032 and #033, #034, #035 and #036, including identifying and implementing interventions.

Related to Log # 004004-18:

A Critical Incident Report (CIR) was submitted to the Director on a specified date for abuse between resident #032 and #033 that resulted in an injury to a specified area.

Review of the health record for resident #032 indicated the resident required the use of a mobility aid but was independent. The progress notes indicated that over a two week period, there were a number of documented altercations between resident #032 and #033. The last altercation resulted in resident #033, sustaining a fall with an injury to a specified area. An identified intervention was put in place for Resident#032 after the incident. Further review of the progress notes for resident #032, related to responsive behaviours, for a specified number of months, indicated there were additional altercations between residents #033, #034, #035 and #036.

Review of the health record for resident #033 indicated the resident was admitted to the home on a specified date as roommate to resident #032 and ambulated with use of a mobility aid.

During separate interviews with Inspector #194, RN #103, #109, DOC, BSO #122 (RPN)

described the interventions for management of the altercations between resident #032 and #033. The staff interviewed indicated that there were no interventions implemented to minimize the risk of altercation for the residents related to the sharing of accommodation.

The current written plan of care for resident #032 related to responsive behaviours, identified specified behaviours/moods and possible triggers, which included resident #033. There were specified interventions included, but none related to the altercations with the shared accommodation.

Related to resident #032, #034, #035 and #036:

Resident #034's was with no responsive behaviours, independent with mobility and was at risk for falls.

Resident #035 was independent with mobility and at risk for falls.

Resident #036 was independent with ambulation, at risk for falls and no responsive behaviours.

On a specified date, Activation staff reported to an RN that resident #036 was triggering resident #032's responsive behaviour. During a one month period, there were a number of documented incidents of a specified responsive behaviour. The documentation described resident #032's responsive behaviour towards resident #036.

During separate Interviews with inspector #194 , RN # 103, #109, and RPN/BSO #122 indicated being aware of resident #032's responsive behaviour and that resident #036 did not have any reaction to the responsive behaviour from resident #032, other than moving away from the resident. During another interview, PSW #110 indicated that resident #036 did not express any concern at the beginning but then began expressing concerns later on.

All staff interviewed, including the DOC, indicated that the intervention being utilized by staff for the responsive behaviour was to monitor and listen for resident #032. The staff would redirect resident #032 or the targeted resident away if resident #032 refused to comply. This interventions was noted by staff interviewed to be effective only some of the time.

During a one month period, there was a number of documented altercations from resident #032 towards resident #034 and #035.

During separate interview with inspector #194, RN #109, RPN/BSO #122, and PSW #127 indicated being aware of the responsive behaviour exhibited by resident #032 towards resident #034 and #035. Staff interviewed indicated that the intervention being utilized by staff for the responsive behaviour was to monitor and listen for resident #032. The staff would redirect resident #032 or remove the other resident away if resident #032 refused to comply. This interventions was noted by staff interviewed to be effective only some of the time.

During interview with inspector #194, resident #034 and #035 indicated not being frightened by resident #032's responsive behaviour but expressed a concern with an identified behaviour.

During interview with inspector #194, PSW #127 expressed that at times resident #035 would appear frightened when resident #032 would demonstrate responsive behaviours at the resident.

During interview with inspector #194, RN #109 verified their documentation in the progress notes on a specified date. The progress note described that resident #032 was exhibiting responsive behaviours more frequently, frightening resident #034, but during this incident resident #032 would not be redirected to the bedroom.

Review of the licensee's responsive behaviour policy " RC-17-01-04", dated February 2017 indicated that:
-Ensure the care plan includes: description of the behaviour, triggers to the behaviour, preventative measures to minimize the risk of behaviour developing or escalating, resident specific interventions to address behaviours and strategies staff are to follow if the interventions are not effective.
-Conduct a more in-depth assessment of behaviour using anyone or combination of the following assessment processes/tools: Dementia Observation System (DOS, Cohen Mansfield Agitation Inventory, Responsive behaviour record (paper), Tool(s) recommended by the local psychogeriatric outreach/support programs, Responsive behaviour debrief tool (Paper or PCC).
-If medication is not effective after this initial documentation, or sooner depending on the severity of the behaviour, refer resident to the physician for reassessment and possible referral to an external psychogeriatric resource.

The licensee failed to ensure that steps were taken to minimize the risk of altercation and potentially harmful interactions of resident #032 when interventions were not identified and implemented for the responsive behaviours involving resident #032 and the responsive behaviour towards residents, #034, #035 and #036. Resident#032 was not referred for psychogeriatric assessment. [s. 54. (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

The licensee did not ensure that the lighting requirements set out in the lighting table were maintained.

During stage one of the RQI, resident #014 indicated to Inspector #111, that the room was too dark where the wardrobe cupboards were located. The resident also indicated having a specified diagnosis which made it harder to see. On the same day, resident #012 indicated to Inspector #111, wished the room was brighter and resident #025 also indicated to Inspector #111, that the room was too dark near the wardrobe cupboards and the resident had a hard time finding clothing. On a separate date and time, the same resident indicated to Inspector #111, the room was too dark and the resident was having a hard time seeing the food they were eating. On another date, resident #002 indicated to Inspector #194, that the lighting beside the bed was too dark. On a separate date, the same resident indicated to Inspector #111, that the room was too dark beside the bed where the resident liked to read.

In addition, there was an outstanding inspection (Log # 025425-17) regarding concerns of low lighting levels in the home but no resident complaints were received at that time.

The long term care home was built prior to 2009, and therefore the section of the lighting table that was applied is titled "In all other areas of the home" . This includes a minimum level of 215.28 lux in resident rooms and corridors and the head of bed at the reading position to be a minimum level of 376.72 lux. A hand held digital light meter was used (Amprobe LM-120) to measure the lux levels in various locations in the home. The meter was held a standard 30 inches above and parallel to the floor. Lighting conditions were overcast outdoors at the time of the inspection and in order to prevent natural light from affecting indoor measurements all efforts were made to control the natural light. Window coverings were drawn in resident bedrooms tested, lights were turned on 5 minutes prior to measuring and doors were closed where possible (i.e. corridors). Areas that could not be tested due to natural light infiltration included the end of hallways close to windows.

The home has 60 beds and is divided into two units as per the following: 7 basic/ward rooms with four beds, 9 semi-private rooms with two beds and 10 private rooms. All resident rooms (with the exception of one semi-private resident room), have a wall-mounted, metal covered, light fixture that is placed approximately two feet above the head of the bed. These light fixtures contain two four foot, linear fluorescent light bulbs (one on top and one underneath). All of the resident bathrooms have a wall-mounted,

ballast light with a frosted plastic cover that is placed approximately six feet high above the sink and toilet. These light fixtures contain one three foot, linear fluorescent light bulb. In the one specified semi-private resident room, there was different lighting and the lighting levels met the requirement.

The hallways in both units have ceiling mounted, dome light fixtures that are approximately two feet in diameter. They have frosted covers with two CFL bulbs. These light fixtures were spaced approximately six feet apart. The lighting levels were measured both directly under the light fixtures and in between the light fixtures through out the hallways. The lighting levels directly under the light fixtures ranged from 160 to 300 lux. The lighting levels in between the light fixtures ranged from 60 to 160 lux.

Only a sample of resident rooms lighting levels were measured. However, since all resident rooms contained the same light fixtures, all resident rooms would be considered to not meet the lighting level requirements. For this sample, two basic, two semi-private and one private resident room was measured as follows:
-An identified semi-private resident room: bathroom lighting ranged from 190 lux in front of sink to 150 lux in front of toilet. Entrance to the room measured 15 lux.
Bed 1:entrance to bed- 60 lux and in front of closet- 25 lux.
Bed 2:entrance to bed-130 lux and in front of closet-40 lux.
-An identified four bed basic resident room: bathroom lighting was greater than 250 lux. Entrance to the room and in front of closets measured 75 lux.
Bed 1: entrance to bed/chair-195 lux, between bed 1 and bed 4 -115 lux,
Bed 2: entrance to bed/chair-100 lux, between bed 2 and bed 3 -65 lux,
Bed 3: entrance to bed/chair-greater than 250 lux,
Bed 4: entrance to bed-greater than 250 lux.
-An identified semi-private resident room: bathroom lighting ranged from 145 lux in front of sink to 115 lux in front of toilet. Entrance to the room measured 20 lux.
Bed 1: entrance to bed-65 lux, FOB/in front of closet-35 lux,
Bed 2: entrance to bed-105 lux, FOB/in front of closet-30 lux.
-An identified four bed basic resident room: bathroom lighting was greater than 250 lux. Entrance to the room measured 15 lux. In front of closets measured 8 lux.
Bed 1: entrance to bed-70 lux, HOB-180 lux, between bed 1 and bed 4-25 lux,
Bed 2:entrance to bed-35 lux, HOB-130 lux, between bed 2 and bed 3- 15 lux,
Bed 3:entrance to bed-130 lux, HOB-350 lux,
Bed 4:entrance to bed-95 lux.
-An identified private resident room: bathroom lighting was greater than 250 lux. The light fixture was missing the plastic cover. The above bed light fixture was also missing the

string to turn on the lower light. The entrance to the room measured 6 lux, the entrance to the bed/chair/closet-75 lux and the HOB measured 80 lux.

During an interview with RPN #106 by Inspector #111, indicated no awareness of lighting concerns in an identified resident room that was missing the light cord for an over bed light fixture and a light fixture cover missing in the bathroom. The RPN indicated any staff who have any maintenance concerns, including lighting repairs should report in the maintenance binder located at the nursing station.

Review of the maintenance binder for a specified period of time, had no documented record of the identified resident room that was missing the light cord for over bed light fixture and bathroom light fixture cover missing.

During an interview with Maintenance #107 by Inspector #111, indicated awareness of low lighting throughout the home. The maintenance indicated low lighting has been a concern for years and had spoken to the Administrator regarding their concerns. The maintenance was not aware the light cord was missing from the over-bed light fixture in an identified resident room or that the cover for the light fixture in the bathroom was also missing.

Interview with the Administrator by Inspector #111 indicated awareness of low lighting throughout the home.

The licensee did not ensure that the lighting requirements set out in the lighting table were maintained. Insufficient lighting levels may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to residents including: the distribution or application of prescribed drugs and treatments; to conduct assessments: to provide treatments. Low levels of illumination and shadows may negatively impact resident's perception of the surrounding environment affecting mobility, nutritional intake, and overall quality of life. [s. 18.]

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 lighting requirements set out in the lighting table are maintained in the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the licensee's Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy (RC-02-01-02) revised April 2017 indicated:
-page 1/5, at a minimum, any individual who witnesses or suspects abuse or neglect of a resident must notify management immediately; Staff must complete an internal incident report.
-page 3/5, immediately respond to any form of alleged, potential, suspected or witnessed abuse; ensure the safety of and provide support to the abuse victim(s) through completion of full assessments, a determination of resident needs and a documented plan to meet those needs; in case of physical and/or sexual abuse, it is imperative to preserve potential evidence as the incident may result in criminal charges and ensure that: accurate detailed descriptions of injuries/condition are documented in the resident chart.

Related to Log #005138-18 and #004990-18:

Review of the progress notes for resident #022 indicated, there was an allegation of resident to resident abuse towards resident #022 that was reported to RN #109 on a specified date. RN #109 documented that a fellow resident had reported witnessing an abusive incident involving a resident from another area. The resident reported the incident had occurred a few days earlier. The RN did not indicate which resident reported the allegation or which resident was involved in the altercation with resident #022. The RN indicated that after speaking to the SDM, went to speak to resident #022 about the incident but the resident was sleeping. The RN indicated was going to complete a Head to Toe Assessment of resident#021 but found resident having a significant change in condition and was not completed. There was no documented evidence the management were notified and there was no internal incident report completed as per the licensee's policy.

Interview with RN #109 by Inspector #111 indicated, the RN was made aware of the alleged resident to resident abuse by resident #026 on a specified date and time. The RN indicated resident #026 reported that on a specified date, resident #026 witnessed resident #021 follow resident #022 into their room, resident #022 then told resident #021 to get out of their room and resident #021 then engaged in an altercation with resident #022. Resident #026 also reported that resident #021 also engaged in abuse towards another resident that was in the same room, but the RN could not recall which resident was involved. The RN confirmed that they only notified the POA of resident #022. The RN indicated the Administrator was notified of the alleged abuse before the POA was contacted but confirmed this was not documented. The RN indicated they would normally document assessments of all residents involved for any alleged abuse but confirmed the RN did not complete the assessments of all residents at the time the allegation was made as per the policy. The RN indicated they were unable to complete or document an assessment for injuries to resident #022 later in the shift due to the resident having a significant change in condition. The RN confirmed that no risk management report was also completed related to the allegation as per the policy.

Interview with RN #103 by Inspector #111, indicated they were working the day after the allegation was made and did not recall being made aware of any allegations of abuse involving resident #021 and resident #022.

Interview with DOC by Inspector #111 indicated they did not have any investigation into the alleged resident to resident abuse involving resident #021 and #022 as the incident was reported to the Administrator.

Interview with Administrator by Inspector #111 indicated, they could not recall whether RN #109 notified the Administrator of alleged resident to resident abuse involving resident #021 and #022, or any other residents. The Administrator indicated that a Risk Management report should have been completed and confirmed no report was completed as per the policy.

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied. [s. 20. (1)]

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 the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: (i) Abuse of a

resident by anyone and ensured that appropriate action was taken in response to every such incident.

Related to Log # 005138-18:

Review of the progress notes for resident #022 indicated, on a specified date and time, RN #109 was made aware of an alleged resident to resident abuse towards resident #022. The RN did not indicate which resident reported the allegation, did not indicate which resident was involved in the abuse and indicated the alleged incident had occurred prior to that date.

Interview with DOC by Inspector #111, indicated they did not have any investigation into the alleged resident to resident abuse incident that was reported on a specified date as the incident was reported to the Administrator.

Interview with Administrator by Inspector #111, indicated they could not recall whether RN #109 reported the alleged resident to resident abuse to the Administrator. The Administrator confirmed there was no documented investigation completed. The Administrator indicated they would usually follow up with any risk management reports completed (internal incident report) but no report was received regarding this incident. The Administrator confirmed that no action were taken in response to the alleged resident to resident abuse incident.

Interview with RN #109 by Inspector #111 indicated, the RN was made aware of the alleged resident to resident abuse by resident #026 on a specified date and time. The RN indicated resident #026 reported that on a prior date and time, resident #026 witnessed resident #021 engage in abuse towards resident #022 in a specified area. Resident #026 also reported that resident #021 also engaged in an abuse towards another resident in the same area, but the RN could not recall which resident was involved in the second incident. The RN indicated the Administrator was notified of the alleged abuse the same day the allegation was received and was asked whether the allegation was to be reported to the Director. The RN confirmed there was no documented assessments completed for any of the residents involved in allegation at the time the allegation was received. The RN also confirmed they did not document that the Administrator was notified. The RN also confirmed that no risk management report was completed related to the allegation of resident to resident abuse.

Interview with RN #103 by Inspector #111 indicated, the RN was working the day after

the allegation was made and did not recall being made aware of any allegations of abuse involving resident #021 and resident #022. The RN indicated they usually reviews the 24 hour report so would have read about the documented allegation. The RN indicated that normally they would have determined which residents were involved in the allegation and then assess the residents involved, but confirmed that this did not occur.

The licensee has failed to ensure that a witnessed incident of resident to resident abuse towards resident #022 that was reported to the licensee, was immediately investigated and appropriate actions were taken in response to the incident. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported, is immediately investigated and appropriate actions are taken in response to each incident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred, or may occur, immediately reported the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Related to Log #005138-18:

Review of the progress notes for resident #022 indicated, on a specified date, RN #109 was made aware of an alleged resident to resident abuse towards resident #022 that had occurred on a previous day.

Interview with RN #109 by Inspector #111 indicated, the RN was made aware of the alleged resident to resident physical abuse by resident #026 on a specified date and time. The RN indicated resident #026 reported that on a previous date, resident #026 witnessed resident #021 engage in abuse towards resident #022 and also engaged in another abuse incident with another resident the same date, but the RN could not recall which resident was involved in the second incident. The RN indicated the Administrator was notified of the alleged abuse and was directed by the Administrator that the allegation did not need to be reported to the Director as there was no injury.

Interview with Administrator by Inspector #111 indicated, they could not recall whether RN #109 notified the Administrator of the alleged resident to resident abuse involving resident #021, #022 and resident #026 as there was no risk report received by the RN.

The licensee has failed to ensure that a person who had reasonable grounds to suspect physical abuse of resident #022 by resident #021, was immediately reported to the Director. [s. 24. (1)]

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 person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.any of the following had occurred, or may occur, immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee failed to ensure that resident #007, #018 and #021's plans of care included bowel management.

During stage 1 of the RQI, worsening incontinence for resident #018, #007 and #021 were triggered in MDS.

Interview with DOC by Inspector #194, confirmed the expectation would have been for the plan of care to be updated to reflect the resident's assessed needs related to continence and bowel management. The DOC confirmed there was nothing in the written plan of care related to bowel management for resident #007, #018 and #021.

Resident #021 required assistance from one staff for activities of daily living (ADL).

Review of MDS assessment for continence on a specified date, indicated that resident #021 was occasionally incontinent of bowels and on a second specified date, indicated the resident was continent. Review of the progress notes for resident #021 related to continence status indicated during a specified month, the resident was frequently noted on the bowel list for bowel protocol and on one specified date, the resident was suspected of having responsive behaviours related to bowels requiring close monitoring. The following month, the resident's health condition was noted to change post bowel management and the resident continued to require use of the bowel protocol. The resident also sustained a fall with injury which required the use of pain medication and affected the resident's bowel management.

Interview with RN #113 indicated that resident #021's bowels were managed with the bowel protocol. RN #113 indicated that an assessment of resident #021 would be completed prior to administration of any bowel protocol.

Interview with RD indicated that resident #021's bowels were managed with use of the bowel protocol as well as with their diet.

Interview with PSW #111 indicated that a change in continence status had been noted during a specified number of months, related to decrease in mobility post injury and without the assistance of a co-resident (that was providing toileting assistance to the resident).

Review of the Medication Administration Record (MAR) for a specified period for resident #021, indicated use of the bowel protocol daily and as needed as per the direction provided.

Review of the plan of care for resident #021 indicated there was no bowel management included in the plan of care for resident #021. [s. 26. (3) 8.]

2. Resident # 018 ambulated independently with use of a mobility aid and required extensive assistance from one staff for ADL.

Review of MDS assessments related to continence on a specified date, indicated that resident #018 was continent of bowels and frequently incontinent of bladder. The next quarter MDS assessment related to continence, indicated that resident #018 was occasionally incontinent of bowels and frequently incontinent of bladder.

RN #103 indicated in interview with inspector #194, that resident #018 was having difficulty with bowel management prior to decline in ambulation (during a specified month). RN #103 indicated that resident #018 had been previously able to toilet independently and did not always report bowel patterns. The RN indicated the resident was now dependent on staff assistance for toileting and the resident has had improved bowel management, requiring less use of bowel protocol, as staff were able to more accurately monitor the resident's bowel patterns.

PSW #104 indicated in interview with inspector #194, that the resident #018's bowel continence had declined during a specified period of time, when the resident level of mobility had changed.

Review of the progress notes for resident #018 related to bowel management for a four month period, indicated the resident required the use of the bowel protocol a specified number of times and was noted to be incontinent of bowel and bladder.

Review of the resident #018's MARS for a specified period, indicated the use of daily bowel management and the use of the bowel protocol as needed.

Resident #018's written plan of care for the specified period, related to continence and bowel management was reviewed by Inspector #194 and bowel management was not included in the plan of care. [s. 26. (3) 8.]

3. Resident #007 is dependent on staff for mobility with a mobility aid and ADL.

Review of the MDS assessments for resident #007, related to continence, indicated on a specified date, the resident was continent of bowels. On a subsequent specified date, the MDS assessment indicated the resident was occasionally incontinent of bowels and on another subsequent date, the MDS assessment indicated that the resident was now frequently incontinent of bowels.

During interview with inspector #194, RN #113 indicated that on an initial date, resident #007 was having difficulty with bowel management and also having decreased level of mobility.

During interview with inspector #194, PSW #110 indicated that resident #007's bowel continence during the specified period, had declined related to the residents level of assistance requirred related to toileting. PSW #110 indicated that resident #007's

continence interventions included a toileting schedule. PSW #110 also indicated that the resident's toileting schedule had not really changed but staff were now more aware when the resident was receiving the bowel protocol and to ensure the resident was being toileting more frequently during those times.

Review of resident #007's progress notes related to bowel continence for the specified period, indicated the resident required the use of the bowel protocol on three separate occasions for bowel management.

Resident #007's plan of care for the specified period, related to bowel continence was reviewed by Inspector #194and bowel elimination was not included in the plan of care. [s. 26. (3) 8.]

4. The licensee has failed to ensure the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including allergies, pain, risk of falls and other special needs.

Related to Log #005138-18 and #004990-18:

Review of the health care record for resident #022 indicated the resident was admitted on a specified date with diagnoses that included cognitive impairment and a terminal illness.

Review of the progress notes for resident #022 indicated the resident sustained two falls since admission. The first fall occurred on a specified date and time and no injuries were sustained. The resident sustained a second fall on a specified date and time (CIR) and had no injuries at the time of the fall, but the resident had significant pain that continued to increase in intensity to a specified area. The resident was transferred to hospital and was diagnosed with an injury to a specified area and passed away in hospital.

In addition, the progress notes for resident #022 indicated the following related to pain:
-on a specified date and time, the physician assessed the resident for new complaints of pain to specified areas and the physician suspected the pain was a result of the terminal illness progressing. The physician ordered routine pain medication at specified times.
-the following day, at a specified time, the resident had decreased level of mobility and continued to complain of pain to a specified area despite routine pain medication and complained of pain to a new area. The staff also noted a change in condition and notified the physician. New orders were received for pain medications related to the new pain.

-the following day, the resident had a significant change in condition related to a medication incident, and complained of pain to a specified area, while toileted.
-the following day, the resident continued to complain of pain to a specified area, had a change in condition and received pain management with good effect.
-two days later, at a specified time, the resident continued to have a change in condition and later the same day, the resident had a significant change in condition, and was complaining of pain to a specified area. The resident was given a specified medication (unrelated to pain) despite continuing to complain of discomfort. The SDM was notified of resident's condition and the SDM requested further direction on whether to transfer the resident to hospital. The RN indicated the resident could remain in the home with pain management. The physician was contacted and ordered additional pain medication for pain management. The resident was given a pain medication via a specified route but remained visibly uncomfortable. At a specified time, the resident was given additional pain medication and a different specified medication.
-on a specified date and time, the resident had visible signs of discomfort and a pain assessment was completed. A pain medication was given with good effect. The following day, the resident denied pain and the physician was notified on the resident's condition. Later the same day, the physician discontinued all non-essential medications.

Review of the written plan of care during a specified time, for resident #022 indicated no planned care for the resident related to pain, despite a painful diagnoses, palliation, new medications ordered related to pain and after the resident sustained a fall resulting in pain.

Interview with DOC by Inspector #111, the DOC confirmed the expectation would have been for the plan of care to be updated to reflect the resident's assessed needs related to falls and pain. The DOC confirmed there was nothing in the written plan of care related to falls or pain for resident #022.

The licensee failed to ensure the written plan of care for resident #022 included pain and risk for falls. [s. 26. (3) 10.]

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 plan of care for residents included bowel management, pain and risk for falls, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

The licensee failed to ensure when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Related to Log # 013973-18:

A complaint was received by the Director from the family of resident #023 indicating the resident had three falls during a specified time and had pain but the SDM was not immediately notified. The complainant also indicated the resident was having a change in condition before the resident passed away and was not made aware for a period of time.

Review of the health record for resident #023 indicated resident had diagnoses that included a terminal illness. Review of the progress notes for resident #023 indicated the resident had sustained a fall on a specified date resulting in ongoing pain to a specified area and also had a change in health condition and a second fall on a specified date, resulting in pain and subsequently died. The resident had complaints of pain as follows:
-on a specified date and time, RN #125 indicated the resident sustained a fall but no pain noted at that time. Later the same day, the resident complained of pain to a specified

area and was given a pain medication. There was no indication a pain assessment was completed. The following day, at a specified time, the resident continued to complain of pain to a specified area. The resident also complained of pain to another specified area. There was no indication the resident was given any pain medication until several hours later, when the resident was given another pain medication. There was no indication a pain assessment was completed at that time. The resident was then absent from the home with the SDM for a specified period of time.
-on a specified date and time (approximately two weeks later), the resident continued to complain of pain to a specified area. The SDM indicated the resident's pain was noted during the absence from the home. The SDM was not made aware of the contributing cause of the pain. There was no documented evidence a pain assessment was completed. A note was left for the physician to assess the resident. Two days later, the resident was assessed by the physician for ongoing complaints of pain to a specified area and indicated the physician was also not made unaware of the contributing cause of the pain. There was no documented evidence a pain assessment was completed. Approximately two weeks later, at a specified time, the resident sustained a second fall but no pain was noted.
-on a specified date and time, the physician spoke to the SDM to discuss changes in the resident's condition and the SDM agreed to comfort care measures with pain management. A pain assessment was completed using the Palliative Performance Scale and revealed no pain at that time. Two days later, RN #109 indicated the resident's condition had deteriorated but no pain.
-the following day (CIR), at a specified time, RN #120 indicated the resident had sustained a fall. The resident complained of pain to a specified area, was returned to bed and given a pain medication. Several hours later, the RN indicated the resident complained of pain to a specified area and no pain medication was given. An hour later, the RN indicated the resident was complaining of increased pain to a specified area restricting the resident's movement and the resident was transferred to hospital for assessment. No pain medication was given and no pain assessments were completed during this shift. The resident was subsequently diagnosed with an injury to a specified area and returned to the home for palliative care with pain medications ordered for pain control. The resident passed away the following day.

Review of the electronic Medication Administrator Records for specified dates (when the resident sustained falls the falls and had pain) for resident #023 indicated the resident received routine pain medications, at specified times and received as needed pain medications as follows:
-during a specified month, the resident received three doses of pain medication at

specified times, for pain to a specified area.
-the following month, the resident received six doses of pain medication at specified times, for pain to a specified area.
-during a specified month, the resident returned from hospital with new pain medications and a pain assessment was completed.

Interview with RN #120 by Inspector #111, the RN indicated awareness of the last fall with resident #023 but was unable to recall what time the fall occurred. The RN indicated the resident only complained of slight pain to a specified area and gave the resident pain medication. The RN indicated later in the shift, the resident was complaining of increased pain to the specified area, the RN re-assessed the resident and noted possible injury to a specified area and sent the resident to hospital for assessment. The RN confirmed that an electronic pain assessment should have been completed and confirmed there was no pain assessment completed for resident #023 at that time.

Interview with the DOC by Inspector #111, indicated the expectation is that all registered nursing staff are to complete an electronic pain assessment with a change in the resident's condition resulting in pain and when new pain medication is started or prescribed by the physician. The DOC confirmed resident #023 did not have pain assessments completed as per the policy.

The licensee failed to ensure that when resident #023 developed new and ongoing pain post fall to a specified area, then later had ongoing pain related to a painful diagnosis and new pain to a specified area post another fall, that a pain assessment was completed, using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee failed to ensure the Director was immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): 5 An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Related to Log #012292-18:

There were three critical incident reports were submitted to the Director for outbreaks in the home and two of the outbreaks were not submitted immediately as follows:
-(CIR) was submitted to the Director two days after an outbreak was declared in the home. There was no after-hours call received for this outbreak.
-(CIR) was submitted to the Director three days after an outbreak was declared in the home. There was no after- hours call received for this outbreak.

Interview with DOC by Inspector #111, the DOC could not indicate why two of the CIR reports were submitted to the Director two to three days later.

The licensee failed to ensure the Director was immediately informed, in as much detail as is possible in the circumstances, of two respiratory outbreaks in the home. [s. 107. (3)]

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 the Director is informed of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, no later than one business day after the occurrence of the incident, followed by the report required under subsection and to ensure the Director is immediately informed of disease outbreaks in the home, immediately, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

The licensee has failed to ensure that: (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed, (b) corrective action is taken as necessary, and (c) a written record is kept everything required under clauses (a) and (b).

Related to Log # 004990-18 and # 005138-18:

A complaint was received from the family of resident #022 regarding a medication incident that occurred.

Review of the medication incident report for resident #022 indicated on a specified date and time, RPN #108 had discovered a specified drug had been given at the incorrect dose. The incident report indicated RPN #108 and RN #109 were involved in the medication incident. The incident report indicated follow-up with each person involved, was left blank.

During an interview with RPN #108 and RN #109 by Inspector #111, they both indicated they could not confirm if the DOC had discussed the medication incident for resident #022 with them or to indicate any actions that were to be taken to prevent a recurrence.

During an interview with the DOC by Inspector #111, the DOC indicated that although the staff involved in the medication incidents are identified on the medication incidents, the DOC had not been documenting the follow up with each person involved in the medication incidents.

The licensee failed to ensure that a medication incident involving resident #022, had documented evidence to indicate the medication incident was analyzed and corrective action was taken to prevent a recurrence [s. 135. (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 all medication incidents and adverse drug reactions are documented, reviewed and analyzed, corrective action is taken as necessary, and a written record is kept of everything required, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Related to Log #004990-18:

Review of the progress notes for resident #022 indicated, there was an allegation of resident to resident abuse towards resident #022. The progress notes indicated on a specified date and time, RN #109 documented the SDM was notified at a specified time of an alleged abuse incident that occurred on a prior date and time. The RN indicated the alleged abuse was witnessed by an unidentified resident and involved resident #022, and two other residents, that were not identified.

Interview with RN #109 by Inspector #111 indicated, the RN was made aware of the alleged resident to resident abuse by resident #026, on a specified date and time. The RN indicated resident #026 reported the incident had occurred on a previous date and reported witnessing resident #021 engage in abuse towards resident #022 and then resident #021 engaged in abuse towards another resident, but the RN could not recall which resident was the recipient in this incident. The RN confirmed that the SDM of resident #022 was only notified.

Review of the progress notes for resident #021 for a specified period, had no documented evidence of the resident to resident abuse incident.

The licensee has failed to ensure that resident's #021's SDM and any other person specified by the resident, were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. [s. 97. (1) (b)]

WN #13: 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 :

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

Related to Log #004990-18 and #005138-18:

A complaint from a family member for resident #022 was received related to concerns with a medication incident that occurred on a specified date, before the resident passed away.

Review of the medication incident report for resident #022 indicated on a specified date and time, RPN #108 had discovered a medication incident.

Review of the progress notes and physician orders for resident #022 indicated on a specified date and time, the resident was complaining of discomfort to a specified area and had unstable vital signs. The physician was contacted and ordered two medications, at specified doses. Later that same day, RPN #108 discovered that one of the medications ordered, was given an incorrect dose and immediately notified the RN. RN #109 notified the physician and was instructed to monitor the resident.

Interview with RPN #108 by Inspector #111, indicated the medication incident involving resident #022 that occurred on a specified date, occurred as a result of improper checks at the time of receipt of the medication from pharmacy and at the time of administration of the drug.

Review of the progress notes for resident #022 also indicated on a specified date and time (after the first incident), RN #109 noted the resident was in respiratory distress and complained of pain to a specified area. The resident was given a specified medication at a specified dose.

Review of the eMAR for for a specified month for resident #022 indicated the specified

drug was to be given as per the directions of the physician. The eMAR indicated the drug was signed as given on the specified date and time, by RPN #116.

Interview with RPN #116 by Inspector #111, confirmed that resident #022 was given the specified medication on the specified date and time. The RPN confirmed awareness the physician order indicated the specified medication was to be given for only for a specified reason and not for the reason it was administered.

Interview with DOC by Inspector #11, indicated drugs administered to residents should only be given as per the directions of the physician and confirmed the specified drug was not given to resident #022 in accordance with the directions by the physician.

The licensee failed to ensure that resident #021 was given a specified medication as prescribed and resident #022 was given a specified medication, not as per the directions provided by the physician. [s. 131. (2)]

Issued on this 10th day of January, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), CHANTAL LAFRENIERE (194)
Inspection No. / No de l'inspection :	2018_643111_0017
Log No. / No de registre :	019219-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 5, 2018
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Haliburton 167 Park Street, P.O. Box 780, HALIBURTON, ON, K0M-1S0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jane Rosenberg

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (5) 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 opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Order / Ordre :

The licensee shall ensure compliance with LTCHA, 2007, s.6(5),

Specifically, the licensee shall:
-retrain all registered nursing staff on ensuring that residents' SDM if any, and any other persons designated by the resident, are notified of any changes to the residents plan of care, especially for falls and new or ongoing pain and keep documented records of the training provided.
-develop a process to identify when SDM's specifically request to be notified at any time, of any significant changes in condition.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident, the SDM if any, and the designate of the resident/ SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

Related to Log #013973-18 and #014133-18:

A complaint was received by the Director from the family of resident #023 regarding failing to call the Substitute Decision Maker (SDM) immediately with any resident concerns and resident #023 had sustained three falls in the home (on specified dates) and the SDM was not immediately notified to participate in actions to be taken.

Review of the health record for resident #023 indicated the resident was no longer in the home. Review of the progress notes for resident #023 indicated the

resident sustained three falls as per the following:
-the first fall occurred on a specified date and time and after the fall, the resident complained of pain to a specified area and was given a pain medication. The following day, the resident continued to complain of pain to the specified area and was guarding the area. The resident was given another pain medication for pain. There was no indication the SDM was notified of the fall the previous evening or the resident's change in condition (continued complaints of pain to a specified area). The resident went on a leave of absence (LOA) with the SDM for a specified period of time. The resident continued to complain of pain to the specified area upon return form the LOA. The SDM reported the resident had complained of pain to the specified area during the LOA. The SDM was still unaware that a fall had occurred resulting in pain to the specified area.
-the second fall occurred on a specified date and time (the following month) and RN #109 indicated the resident sustained a fall in the bathroom. No injuries or pain noted. The RN indicated the SDM was to be notified at a later time but there was no indication the SDM was notified.
-approximately two days later, the SDM was visiting the resident when the resident's room mate informed the SDM the resident had sustained a fall two days earlier. The registered staff confirmed the SDM was not informed of the fall the previous month or the fall two days prior. The SDM reminded staff to notify the SDM at any time. Staff indicated they were unable to document the SDM's request.
-five months later, the SDM reminded staff again to contact the SDM at any time with any changes in the residents condition.
-four days later (CIR) at specified time, RN #120 indicated the resident sustained a fall from the bed and complained of pain to a specified area. The resident was returned to bed and pain medication was given. Approximately five hours later, RN #120 indicated the resident continued to complain pain to the specified area but no indication pain medication was given. Approximately one hour later, RN #120 indicated the resident was suspected of an injury to a specified area due to increased complaints of pain to the specified area and the resident was transferred to hospital for assessment. The SDM was contacted at that time. The SDM was notified at that time. The Medical Director reported the resident sustained an injury to a specified area and would return to the home for comfort care. The resident passed away the following evening.

Interview with RN #120 by Inspector #11, indicated awareness of fall with

resident #023 but was unable to recall what time the fall occurred. The RN indicated the resident only complained of slight pain in a specified area and gave the resident a pain medication. The RN indicated later in their shift, the resident was complaining of increased pain to the specified area. The RN indicated 911 was called and at that time the SDM was also notified of the fall and transfer to hospital. The RN indicated the SDM was not notified of the fall at the time of the fall. The RN indicated the SDM was not immediately informed about the fall.

Interview with the DOC by Inspector #111, indicated the expectation is that all registered nursing staff are to notify the SDMs of any falls or change in resident's condition immediately, unless the family specifically request not to be called.

The licensee failed to ensure the SDM of resident #023 had been provided the opportunity to participate fully in the development and implementation of the plan of care. The SDM of resident #023 was not informed of a fall that occurred on a specified date until approximately one month later. The SDM was not informed of a second fall that occurred on a specified date until two days later when the SDM was informed of the fall by a co-resident. The SDM was also not informed of a third fall that occurred on on a specified date and time until a number of hours later, when the resident was being transferred to hospital for assessment.

The scope was a level 2, pattern as 2 out of 3 residents that were reviewed did not have the SDM informed. The severity was a level 4, actual harm/actual risk as three out of three residents reviewed for falls had sustained serious injury and/or died. The compliance history was a level 3 and indicated the licensee had been issued a Voluntary Plan of Correction (VPC) for LTCHA, 2007, s.6 related to falls on May 6, 2016 during inspection # 2016_178624_0008 and a VPC for LTCHA, 2007, s.6 related to falls on July 27, 2015 during inspection #2015_365194_0018. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 15, 2019

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall be compliant with O.Reg. 79/10, s.8(1)(a)(b).

Specifically, the licensee shall:
1.Retrain all registered nursing staff and keep records of the re-training on the home's pain management policy to ensure:
- staff are aware and completing the appropriate pain assessments as per the licensee's policy when any resident develops new pain, has ongoing pain that is not relieved with initial interventions, or when a new pain medication is ordered by the physician or NP,
-staff notify the physician or NP is notified when the resident develops new pain, has pain not relieved with initial interventions.
-staff to update the resident's care plan to reflect pain management strategies.
-keep documentation of the educational content of the training and staff trained.

2.Retrain all registered nursing staff on the home's continence and bowel management policy to ensure:
- staff are aware and completing the appropriate continence and bowel assessments as per the licensee's policy when any resident has a change in continence,
-staff to update the resident's care plan to reflect current continence and bowel management strategies.
- keep documentation of the educational content of the training and staff trained

Grounds / Motifs :

1. The licensee failed to ensure that 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 is complied with.

Under O.Reg.79/10, s.52 (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.
2. Strategies to manage pain, including non-pharmacological interventions, equipment, supplies, devices and assistive aids.
3. Comfort care measures
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.
(2)Every licensee of a Long-Term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Review of the licensee's Pain Identification and Management policy (RC-19-01-01) revised February 2017 indicated:
-on page 1, 2/5, assess residents for pain using the Pain Flow Note in PCC (if resident is non-verbal or cognitively impaired, use the PAINAD). A pain flow note will be completed on all residents who meet any of the following criteria: resident states they have pain, any change in condition that has the potential to impact the resident pain level, new diagnosis of painful disease, taking new pain-related medication for less than 72 hours, taking an increased dose and/or frequency of pain-related medications, distress as observed through facial grimacing, guarding, or holding an area of the body, etc.
-on page 3/5, notify the physician of the residents pain including the analysis of the assessments if the resident reports sudden onset of new pain or worsening pain or when the resident consistently reports pain for 24 hours, complete referrals to other internal/external disciplines such as physiotherapy or massage therapy and/or external pain specialist as appropriate; assess the effectiveness of pain control strategies pre and post intervention and determine if the effect of

the intervention meets the residents goal for pain management or if pain requires further adjustment; update the resident's care plan to reflect pain management strategies.

A. Related to Log #005138-18 and Log #004990-18:

Log #005138-18:
A complaint was received from a family member for resident #022 regarding the resident having a significant change in condition following a medication incident and regarding a fall.

Log #004990-18:
A critical incident report (CIS) was submitted to the Director on a specified date, for a fall that occurred on a specified date and time, that resulted in transfer to hospital and a significant change in condition. The CIS indicated the resident sustained an injury to a specified area as a result. The CIS was amended and indicated the resident passed away two days later.

Review of the progress notes for resident #022 indicated:
- On a specified date and time, the resident reported new complaints of pain to specified areas to RN #103. No pain medication was given. The physician later assessed the resident for new complaints of pain and ordered a new pain medication. Later the same day, the resident continued to complain of pain to the specified area and the pain medication was started at that time. The resident continued to complain of pain to the specified area, despite the use of the new pain medication. Later that same day, RN #125 indicated the resident continued to complain of pain to the specified area and to monitor for need for stronger pain medication but no pain medication was offered at that time.
-On a specified date and time, RN #103 indicated the resident continued to have complaints of pain in a specified area. The RN notified the physician and new medications were ordered.
-The following day, an RN indicated the resident continued to complain of pain to specified area, the physician was contacted and ordered one of the new pain medications were ordered held for a specified period. The following day, at a specified time, the resident appeared in discomfort and with a significant change in condition. A medication was given with good effect, but still uncomfortable and the SDM was notified. The SDM agreed to keep the resident in the home on

comfort measures. The RN contacted the physician and additional pain medications were ordered for comfort care. The following day, the resident continued to have visible signs of discomfort and a pain assessment was completed at that time. Two days later, the resident subsequently died.

Review of the written plan of care (in place at that time) for resident #022 indicated no planned care related to new diagnosis of painful disease, ongoing complaints of pain to specified areas, palliative care, new pain medications ordered and the resident sustaining a fall resulting in pain to a specified area.

Review of the electronic pain assessments for resident #022 indicated a pain assessment was completed on a specified date and time and the resident's pain level was low but the rest of the pain assessment was incomplete. The next pain assessment was completed the following day and indicated the residents pain level was high, indicated the location of the pain, what caused the pain and the pain was constant. There were no other pain assessments documented despite the resident developing new pain to a specified area on a specified date and receiving a new pain medication. There was no pain assessment completed when the resident developed a different pain on two separate dates and had a medication ordered. There was no pain assessment completed when the resident was also started on new pain medication on a specified date, and which was later increased two days later.

During an interview with RN #103 by Inspector #111, the RN indicated, when a residents health condition starts to deteriorate, they would contact the family for wishes, and then contact the physician to receive orders for end of life. The RN indicated they would complete the Palliative Care Physician Order Set form. The RN indicated the care plan would be updated to reflect palliative care status and also complete the Palliative Performance Scale (PPS) for pain relief on PCC. The RN confirmed that no pain assessment was completed for resident #022 until the resident was ordered end of life pain medications, despite new complaints of pain, and pain after sustaining a fall. The RN confirmed they were working when a medication incident involving resident #022 occurred, the physician was notified with new orders and confirmed the order was not transcribed. The RN indicated they were also working on an identified date, when resident #022 had a significant change in condition. The RN indicated they contacted the SDM to update on the residents condition and confirmed they

should have called the physician first for direction on whether to send the resident to the hospital or call 911. The RN indicated that on specified date and time, the RN received in report that resident #022 was having pain. The RN indicated when the PSW's went to provide care to the resident, they requested the RN come to assess the resident for complaints of pain to a specified area. The RN indicated they immediately went to assess the resident and noted possible injury to a specified area, called 911 and also notified the SDM. The RN confirmed no pain assessment was completed for any of the incidents.

During an interview with the DOC by Inspector #111, the DOC indicated, the expectation is that all registered nursing staff are to complete a pain assessment for all residents with a change in condition resulting in pain and offer the resident pain medication as appropriate. The DOC indicated the expectation was that registered nursing staff are to notify the physician with any change in the resident's condition resulting in new pain or ongoing pain that is not relieved with pain medication provided. The DOC indicated the resident`s plan of care is to be updated to include pain and interventions to manage the pain. The DOC confirmed resident #022 did not have appropriate pain flow notes and pain assessment tool completed, the physician was not notified when the resident had new pain and the residents care plan was not updated.

B. Related to Log # 013973-18 and Log # 014133-18:

Review of the health record for resident #023 indicated the resident had sustained a fall on a specified date, which resulted in ongoing pain to a specified area. The resident also sustained a change in health status with a new painful diagnosis and another fall on a specified date, resulting in pain. The resident died on a specified area. The resident had complaints of pain and there was no indication the pain policy was complied with as follows:
-on a specified date and time, an RN indicated the resident sustained a fall but no injuries or pain noted at that time. At a specified time, the resident complained of pain to a specified area and was given a pain medication. There was no pain flow note completed, the physician was not notified of the fall with new pain and there was no post assessment from the next shift to determine if the analgesic was effective in managing the residents pain, as per the policy. The following day, at a specified time, the resident continued to complain of pain to the specified area and there was no indication the resident was given any

pain medication until a number of hours later, when the resident was given another pain medication. There was no indication a pain flow note was completed, the resident was assessed post administration of analgesic on the next shift to determine effectiveness, or to indicate the physician was notified as per the policy. The following day and at a specified time, the resident continued to complain of pain to the specified area. There was no indication pain medication was offered, a pain assessment was completed and no indication the physician was notified as per the policy. The resident then went on a leave of absence (LOA) with the SDM.
-on a specified date and time, the resident continued to complain of pain to the specified area, indicated the pain had been ongoing and was getting worse. The SDM reported the resident's pain was first noticed by the SDM when going out on the LOA and a note was left for the physician to assess. There was no indication the resident was offered any pain medication despite complaining of pain to a specified area and was getting worse, there was no documented evidence a pain flow note was completed or the plan of care updated related to new pain as per the policy. On a specified date and time, the resident was assessed by the physician for ongoing complaints of pain to a specified area and indicated the resident reported the pain to specified area for a few days and resident unable to recall falling. The physician was unaware that a fall had occurred and the resident had ongoing complaints of pain to a specified area that was getting worse since the fall. There was no documented evidence the resident was offered pain medication, a pain flow note was completed and no indication the resident`s care plan was updated as per the policy.
-on a specified date and time, the physician discussed the residents deteriorating condition with the SDM and comfort care was ordered. A pain assessment was completed at this time but no indication the resident`s care plan was updated as per the policy.
-on a specified date and time (CIR), RN #120 indicated the resident sustained a fall from bed. The resident complained of pain to specified areas, hourly checks to be completed and a specified pain medication was given. There was no indication a pain flow note was completed to determine the effectiveness of the pain medication and there was no indication on the electronic Medication Administration Record of the pain medication given to indicate time and dose given. Later in the shift, the RN indicated the resident complained of "some tenderness" to a specified area but no indication pain medication was offered. An hour later, RN #120 indicated the resident had been favoring a specified area

during most of the shift, complaining of increased pain, unable to move easily. 911 was called and the resident was transferred to hospital at that time. The Medical Director reported the resident sustained an injury to a specified area and would return to the home for palliative care. New pain medications were ordered and the resident subsequently passed away.

Review of the electronic Medication Administrator Records for specified dates, for resident #023 indicated, despite the resident having ongoing complaints of pain to a specified area, received prn narcotic analgesic as follows:
-during the first month, received the pain medication on two separate dates and times.
-during the second month, received the pain medication on five separate dates and times.
-after a subsequent fall, there was no indication the resident received PRN pain medication despite complaints of severe pain to a specified area.

During an interview with RN #120 by Inspector #111, the RN indicated, awareness of fall with resident #023 on a specified date, but was unable to recall what time the fall occurred. The RN indicated the resident only complained of slight pain to a specified area at time of the fall and gave the resident pain medication that was effective. The RN could not recall how much pain medication was given, what time the medication was given, why there was no documented evidence of the pain medication being given or no documentation of the effectiveness of the pain medication. The RN indicated later in the shift, the PSWs reported the resident was complaining of severe pain to a specified area. The RN indicated the resident was assessed, noted the resident was in severe pain to the specified area. The RN indicated 911 was called and the resident was transferred to hospital for assessment. The RN could not indicate why the resident was not offered any pain medication at that time, despite complaints of severe pain to the specified area. The RN confirmed a pain assessment was not completed as per the policy. The RN indicated PSW#117 and #121 were also working when the fall occurred.

During an interview with PSW #121 by Inspector #111, the PSW indicated, awareness of resident #023 sustaining a fall on a specified date and time, as the PSW initially responded to the fall. The PSW indicated that the resident complained of pain to specified areas at the time of the fall. The PSW indicated

they assumed the RN was assessing the resident hourly post fall, as per the policy. The PSW indicated later in the shift, PSW #117 and #121 went to provide toileting to resident #023, the resident was in increased pain and unable to move a specified area. The PSW indicated they notified the RN immediately.

During an interview with PSW #117 by Inspector #111, the PSW indicated, awareness of resident #023 sustaining a fall on a specified date and time. The PSW was not present when the fall occurred and indicated that PSW #121 and RN #120 responded to the fall. The PSW indicated they usually check and/or toilet the residents twice a shift. The PSW indicated when they started their last check (at a specified time), they could hear resident #023 screaming out in pain. The PSW indicated they immediately went into the resident's room and the resident was unable to move due the increased complaints of pain. The PSW indicated RN #120 was immediately notified.

During an interview with the DOC by Inspector #111, the DOC indicated the expectation is that all registered nursing staff are to complete a pain assessment for all residents with a change in condition resulting in pain and offer the resident analgesic as appropriate. The DOC indicated the expectation was that registered nursing staff are to notify the physician with any change in the resident's condition resulting in new pain or ongoing pain that is not relieved with pain medication provided. The DOC indicated the resident`s plan of care is to be updated to include pain and interventions to manage the pain. The DOC confirmed resident #023 did not have appropriate pain flow notes completed, appropriate pain assessment tool completed, the physician notified when the resident sustained a fall with ongoing pain to a specified area until a month later, and the residents care plan was not updated.

The licensee failed to ensure the Pain Identification and Management policy was complied with, as resident #023 had ongoing complaints of pain to a specified area (post fall) for a specified period of time and the physician was not informed of the fall with new pain or ongoing pain. No pain assessment was completed during that time and the care plan was not updated to reflect the new pain. On a specified date, when the resident had a new painful diagnosis, the care plan was not updated. On a specified date, when the resident sustained a fall with new pain to a specified area, was not given analgesic and was also not given analgesic when the pain level increased.

The scope was a level 2, as two out of three residents reviewed did not have the pain management policy complied with. The severity was a level 3 as two out of the three residents reviewed had actual harm, severe pain. Review of the licensee's compliance history was a level 3, indicating a Voluntary Plan of Correction (VPC) was issued for O.Reg. 79/10, s. 8(1)(b) on March 15, 2016 during inspection # 2016_178624_0008 and a VPC was issued for O.Reg. 79/10, s. 8(1)(b) on November 15, 2015 during inspection # 2015_328571_0010. (111)

2. Under O.Reg. 79/10, s. 51(1)The continence care and bowel management program must, at a minimum, provide for the following:
(2) (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.

Review of the licensee "Continence Management Program" policy # RC 14-01-01 dated February 2017 was completed by inspector #194 and indicated:
-complete a continence assessment using a clinically appropriate assessment tool that is specifically designed for assessing continence. An assessment is completed with any deterioration in continence level.

An interview with RN #103 was completed by Inspector #194, related to continence assessment being used at the home. RN #103 provided a copy of the electronic "Continence Assessment –V3" and stated that the home used a "quick reference" sheet located at the nursing station which is laminated indicating that continence assessments, that a "3 day elimination monitoring tool" is also to be completed with a change in the resident's continence status.

An interview with RAI Coordinator #105 was conducted by Inspector #194, related to completion of continence assessments for residents in the home. The RAI Coordinator indicated that the continence assessments for residents in the home were to be completed by the registered staff on the unit.

A. During stage 1 of the RQI, worsening incontinence for resident #018 was triggered in MDS.

Resident #018 ambulated independently with use of mobility aid and required extensive assistance from one staff for activities of daily living (ADL).

Review of MDS related to continence on a specified date, indicated that resident #018 was continent of bowel and frequently incontinent of bladder. The next quarter MDS related to continence indicated resident #018 was frequently incontinent of bowel and bladder.

An interview with PSW #104 was conducted by Inspector #194 related to continence status for resident #018. PSW #104 verified that resident #018 had a change in continence status over an identified period related to increase pain in the resident's feet resulting in a decrease in mobility for the resident.

An interview with RN #103 was conducted by Inspector #194, related to continence status for resident #018 during a four month period. RN #103 indicated being aware that resident #018 had a change in continence status. Inspector #194 and RN #103 reviewed the clinical health record for resident #018 with no evidence of a continence assessment being completed for that period of time when a change in continence status was indicated in MDS.

B. During stage 1 of the RQI, worsening incontinence for resident #007 was triggered in MDS.

Review of the MDS assessment related to continence on specified date, indicated that resident #007 was continent of bowel, the following MDS assessment indicated resident #007 to be occasionally incontinent of bowel and on a subsequent MDS assessment, indicated that resident #007 was now frequently incontinent of bowel.

Resident #007 is dependent on staff for mobility and ADL.

During interview with Inspector #194, RN #113 indicated that during a specified date, resident #007 was suffering with constipation issues. RN #113 explained that resident #007's mobility had decreased during this period.

During interview with Inspector #194, PSW #110 indicated that resident #007's bowel continence during a specified period had declined. PSW #110 indicated that resident #007 had an increase in incontinence related to the resident's inability to consistently call staff for assistance to the bathroom.

Review of the clinical health record for resident #007 was completed with no evidence of a Continence assessment being completed when MDS assessments indicated a changed in continence status for the resident.

C. Review of the MDS assessment related to continence on a specified date, indicated that resident #021 was occasionally incontinent of bowel and frequently incontinent of bladder. The following quarterly MDS assessment indicated that resident #021 was continent of bowel and frequently incontinent of bladder.

Resident #021 is independent with ambulation but required assistance from one staff for transferring and ADL.

An interview with PSW #111 indicated a change in resident #021's continence status had been noted during a specified period of time. PSW #111 described resident #21 as being independent with mobility and toileting, relying on a co-resident in the home for assistance. PSW #111 indicated that resident #021 had been independent with continence and not a reliable source for bowel movements. PSW #111 indicated that after the resident #021 sustained an injury to a specified area, the resident was more dependent on staff for toileting and bowel movements were more easily monitored.

RN #113 indicated that resident #021 was noted to have a change in status during this period related to concerns with a specified area and staff were trying to keep bowels soft to relieve any pain. RN #113 indicated that resident #021 did have a general decline in health status during this period but was not aware of any changes in continence status for the resident.

Review of the clinical health record for resident #021 was completed with no evidence of a Continence assessment being completed when MDS assessments specific to continence on two specified dates indicated a change in

continence status for the resident.

The licensee failed to ensure the Continence Management Program (policy # RC 14-01-01 dated February 2017) was complied with for resident #007, #018 and #021 as there was no continence assessment completed using a clinically appropriate assessment tool that is specifically designed for assessing continence, when the resident's had any deterioration in continence level.

The scope was a level 3, as three out of three residents reviewed did not have the licensee's policy for continence and bowel management complied with. The severity was a level 3 as the three residents all had a negative outcome as a result of the policy not being complied with. The compliance history was a level 3 and indicated a VPC was issued for O.Reg. 79/10, s.8(1)(b) on March 15, 2016 during inspection #2016_328571_0010 and a VPC was issued for O.Reg. 79/10, s.8(1)(b) on November 15, 2015 during inspection #2015_328571_0010. (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 15, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee shall be compliant with O.Reg .79/10, s. 54(b).

Specifically, the Licensee is ordered to:
Develop, implement and submit a corrective action plan to include which staff will be responsible for each action and date when action is completed to include the following:
1- Re-educate all Registered staff on the licensee's policy entitled Responsive Behaviour "RC-17-01-04, dated February 2017.
2. Re-educate all front line staff (RN's, RPN's, PSW's) regarding when to implement assessments specific to responsive behaviours, DOS, Cohen Mansfield Agitation Inventory, Responsive Behaviour Record (paper), Responsive behaviour debrief tool (Paper or PCC) as noted in the policy.
3. Keep a documented record of the education completed by staff.
4. Develop and implement a process to identify residents exhibiting responsive behaviours involving potentially harmful interactions between residents and keep a documented record.

The corrective action plan is to be submitted via email to: MOHLTCIBCentralE@ontario.ca by December 20, 2018.

Grounds / Motifs :

1. The licensee failed to ensure that steps are taken to minimize the risk of

altercation and potentially harmful interactions between resident #032 and #033, #034, #035 and #036, including identifying and implementing interventions.

Related to Log # 004004-18:

A Critical Incident Report (CIR) was submitted to the Director on a specified date for abuse between resident #032 and #033 that resulted in an injury to a specified area.

Review of the health record for resident #032 indicated the resident required the use of a mobility aid but was independent. The progress notes indicated that over a two week period, there were a number of documented altercations between resident #032 and #033. The last altercation resulted in resident #033, sustaining a fall with an injury to a specified area. An identified intervention was put in place for Resident#032 after the incident. Further review of the progress notes for resident #032, related to responsive behaviours, for a specified number of months, indicated there were additional altercations between residents #033, #034, #035 and #036.

Review of the health record for resident #033 indicated the resident was admitted to the home on a specified date as roommate to resident #032 and ambulated with use of a mobility aid.

During separate interviews with Inspector #194, RN #103, #109, DOC, BSO #122 (RPN) described the interventions for management of the altercations between resident #032 and #033. The staff interviewed indicated that there were no interventions implemented to minimize the risk of altercation for the residents related to the sharing of accommodation.

The current written plan of care for resident #032 related to responsive behaviours, identified specified behaviours/moods and possible triggers, which included resident #033. There were specified interventions included, but none related to the altercations with the shared accommodation.

Related to resident #032, #034, #035 and #036:

Resident #034's was with no responsive behaviours, independent with mobility

and was at risk for falls.

Resident #035 was independent with mobility and at risk for falls.

Resident #036 was independent with ambulation, at risk for falls and no responsive behaviours.

On a specified date, Activation staff reported to an RN that resident #036 was triggering resident #032's responsive behaviour. During a one month period, there were a number of documented incidents of a specified responsive behaviour. The documentation described resident #032's responsive behaviour towards resident #036.

During separate Interviews with inspector #194 , RN # 103, #109, and RPN/BSO #122 indicated being aware of resident #032's responsive behaviour and that resident #036 did not have any reaction to the responsive behaviour from resident #032, other than moving away from the resident. During another interview, PSW #110 indicated that resident #036 did not express any concern at the beginning but then began expressing concerns later on.

All staff interviewed, including the DOC, indicated that the intervention being utilized by staff for the responsive behaviour was to monitor and listen for resident #032. The staff would redirect resident #032 or the targeted resident away if resident #032 refused to comply. This interventions was noted by staff interviewed to be effective only some of the time.

During a one month period, there was a number of documented altercations from resident #032 towards resident #034 and #035.

During separate interview with inspector #194, RN #109, RPN/BSO #122, and PSW #127 indicated being aware of the responsive behaviour exhibited by resident #032 towards resident #034 and #035. Staff interviewed indicated that the intervention being utilized by staff for the responsive behaviour was to monitor and listen for resident #032. The staff would redirect resident #032 or remove the other resident away if resident #032 refused to comply. This interventions was noted by staff interviewed to be effective only some of the time.

During interview with inspector #194, resident #034 and #035 indicated not being frightened by resident #032's responsive behaviour but expressed a concern with an identified behaviour.

During interview with inspector #194, PSW #127 expressed that at times resident #035 would appear frightened when resident #032 would demonstrate responsive behaviours at the resident.

During interview with inspector #194, RN #109 verified their documentation in the progress notes on a specified date. The progress note described that resident #032 was exhibiting responsive behaviours more frequently, frightening resident #034, but during this incident resident #032 would not be redirected to the bedroom.

Review of the licensee's responsive behaviour policy " RC-17-01-04", dated February 2017 indicated that:
-Ensure the care plan includes: description of the behaviour, triggers to the behaviour, preventative measures to minimize the risk of behaviour developing or escalating, resident specific interventions to address behaviours and strategies staff are to follow if the interventions are not effective.
-Conduct a more in-depth assessment of behaviour using anyone or combination of the following assessment processes/tools: Dementia Observation System (DOS, Cohen Mansfield Agitation Inventory, Responsive behaviour record (paper), Tool(s) recommended by the local psychogeriatric outreach/support programs, Responsive behaviour debrief tool (Paper or PCC).
-If medication is not effective after this initial documentation, or sooner depending on the severity of the behaviour, refer resident to the physician for reassessment and possible referral to an external psychogeriatric resource.

The licensee failed to ensure that steps were taken to minimize the risk of altercation and potentially harmful interactions of resident #032 when interventions were not identified and implemented for the responsive behaviours involving resident #032 and the responsive behaviour towards residents, #034, #035 and #036. Resident#032 was not referred for psychogeriatric assessment.

The scope was a level 1, as only one resident was identified as demonstrating

altercations. The severity was a level 3, as there was ongoing actual harm by resident #032, towards four different residents. The compliance history was a level 2, as there was no prior compliance history related to O.Reg. 79/10, s.54. (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 15, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee shall ensure compliance with LTCHA, 2007, s.6(11)(b).

Specifically, the licensee shall:
-Ensure that any resident at moderate to high risk for falls are reassessed after each fall and the plan of care is reviewed and revised, when the care set out in the plan has not been effective and different approaches are considered in the revision of the plan of care and this information is documented.
-Review and revise the plan of care for all residents identified at moderate to high risk for falls (as per the Falls Assessment tool on PCC), to ensure that different approaches are considered in the revision of the plan of care, when the interventions have not been effective in reducing falls or severity of injury.
-Complete interdisciplinary Falls Prevention meetings as per the licensee policy, to ensure that all residents at moderate to high risk for falls are identified, and interventions are identified and a process is in place to ensure the interventions are shared with the rest of staff providing care to those residents.

Grounds / Motifs :

1. 3. The licensee has failed to ensure that when the resident was being reassessed, the plan of care was revised because care set out in the plan had not been effective and different approaches had been considered in the revision of the plan of care.

Related to Log #002729-18:

A critical incident report (CIR) was submitted to the Director on a specified date for a fall that resulted in transfer to hospital and significant change in condition. The CIR indicated on a specified date and time, resident #024 was being transferred in a mobility aid by PSW #121 when the resident sustained a fall, sustaining an injury to a specified area. The resident was transferred to hospital and returned to the home for comfort care. The resident passed away the following day. The CIR indicated this was the resident's second fall in a specified period of time.

Review of the health care record for resident #024 indicated the resident had only been in the home for a short period of time. The progress notes indicated during that time, the resident had sustained multiple falls. After the second last fall, the DOC noted the resident had sustained multiple falls, identified possible causes and to order specified fall protective equipment. After the last fall (CIR), an alarming device and one to one monitoring was implemented. The resident died approximately two weeks later.

Review of the written plan of care for resident #024 indicated the resident was at risk for falls. There were specified interventions identified on admission. Additional specified interventions were not considered until after the last fall.

During an interview with the DOC by Inspector #111, the DOC confirmed that resident #024 was a high risk for falls and had sustained multiple falls over a short period of time in the home. The DOC confirmed resident #024 had not been discussed at the falls prevention meeting because the resident had been admitted after one meeting and had passed away before the next meeting. The DOC confirmed that additional interventions were not considered until after multiple falls had already occurred.

The licensee had failed to ensure that when resident #024 was being reassessed after each fall, the plan of care was revised when the care set out in the plan had not been effective and different approaches had been considered in the revision of the plan of care, as different approaches were not considered until after multiple falls.

The scope was a level 2, pattern, as 2 out of 3 residents that were reviewed did not have the plan of care revised to include different approaches when the plan had not been effective related to falls. The severity was a level 4, actual harm/actual risk as three out of three residents reviewed for falls had sustained serious injury and/or died. The compliance history was a level 3 and indicated the licensee had been issued a Voluntary Plan of Correction (VPC) for LTCHA, 2007, s.6 (11)(b) related to falls on May 6, 2016 during inspection # 2016_178624_0008 and a VPC for LTCHA, 2007, s.6 (11)(b) related to falls on July 27, 2015 during inspection #2015_365194_0018. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 15, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 5th day of December, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Central East Service Area Office