Ontario

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

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

Ottawa District
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Ottawa, ON, K1S 3J4
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Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: September 25, 2023
Original Report Issue Date: August 14, 2023
Inspection Number: 2023-1551-0003 (A1)
Inspection Type: Complaint Follow up
Licensee: Corporation of the City of Cornwall
Long Term Care Home and City: Glen-Stor-Dun Lodge,Cornwall

Amended By	**Inspector who Amended Digital Signature**
Lisa Cummings (756)	Lisa Cummings Digitally signed by Lisa Cummings Date: 2023.10.05 10:59:08 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Compliance orders #001, #002, #003, #004, #005, and #006 had a compliance due date of September 25, 2023. A request for an extension to the compliance due date for the listed compliance orders was received and was approved. The compliance order due dates were amended to reflect the approved compliance due date extension of November 15, 2023.

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Long Term Care Home and City: Glen-Stor-Dun Lodge, Cornwall	
Lead Inspector Michelle Edwards (655)	**Additional Inspector(s)** Stephanie Fitzgerald (741726) Heath Heffernan (622) Lisa Cummings (756)
Amended By Lisa Cummings (756)	**Inspector who Amended Digital Signature**

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 19, 20, 21, 24-27, 2023, May 1-5, 8-12, 15-19, 23-26, 29-31, 2023 and June 1, 2, 5, 6, 14-16, 20, 2023.
The inspection occurred offsite on the following date(s): April 27, 28, 2023, May 9, 10, 30, 2023 and June 2, 6, 7, 9, 12, 21, 22, 23, 29, 2023.

The following intake(s) were inspected:
• Intake: #00015725 - Follow-up to CO #001 from report 2022_1551_0001,
• Intake: #00015535 - Follow-up to CO #001 from report 2022_1551_002,
• Intake: #00015536 - Follow-up to CO #002 from report 2022_1551_002,
• Intake: #00015538 - Follow-up to CO #003 from report 2022_1551_002,
• Intake: #00004756 - Complaint related to multiple care concerns,
• Intake: #00016299 - Complaint related to the quality of care and safety of residents,
• Intake: #00016399 - Complaint related to concerns with nursing and personal support services, lack of assessments, re-positioning and call bell concerns,
• Intake #00016623 and Intake #00018830 - Complaint related to infection prevention and control, housekeeping, nursing and personal support services, responsive behaviors, maintenance services, and falls prevention and management,
• Intake: #00019091 - Complaint related to a resident's substitute decision maker not being kept informed, and other care concerns,
• Intake: #00020998 - Complaint related to staffing and plan of care concerns,
• Intake: #00087313 - Complaint related head injury routines not being completed when required, and documentation being falsified,
• Intake: #00090780 - Complaint related to infection prevention and control, and allegedly unaccounted for controlled substances; and,
• Intake #00017429/CIS report #M529-000001-23 - related to a fall that caused injury to a resident for which the resident was taken to hospital.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2022-1551-0002 related to LTCHA, 2007 S.O. 2007, c.8, s. 6 (4) (a) inspected by Michelle Edwards (655)

Order #002 from Inspection #2022-1551-0002 related to FLTCA, 2021, s. 6 (7) inspected by Michelle Edwards (655)

Order #001 from Inspection #2022-1551-0001 related to O. Reg. 246/22, s. 102 (15) 2. inspected by Michelle Edwards (655)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #003 from Inspection #2022-1551-0002 related to O. Reg. 79/10, s. 114 (3) (a) inspected by Michelle Edwards (655)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must comply

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 101 (4)

The licensee has failed to comply with compliance order (CO) #003 from inspection #2022-1551-0002, served on November 3, 2022, with a compliance due date of March 16, 2023.

The existing written policies and protocols related to the medication-reconciliation process for resident's returning to the long-term care home after a period of hospitalization were not evaluated or updated if required; and, the required monitoring and remedial processes related to adherence by registered nursing staff to the licensee's medication reconciliation policies were not developed or implemented.

Rationale and Summary
Over the course of the inspection, Inspector #655 reviewed all records contained within the licensee's compliance binder related to actions taken to address three separate compliance orders issued in inspection 2022_1551_0002. In the binder provided, however, there was no record of any actions taken to comply with CO #003 specifically.

Inspector #655 interviewed numerous individuals, including members of the past and present leadership team, and members of the registered nursing staff who were identified as having been involved in addressing the compliance orders. No one who was interviewed could confirm that the steps required under CO #003 had been completed.

Sources: CO #003 from #2022-1551-0002; the home's compliance binder, including an internal action plan and related records; interviews with staff including the RAI-Admissions Coordinator/RPN, the RAI Coordinator, the NP/DOC, the DOC, the Deputy Administrator, and the Staff Development/Health & Safety Officer.

[655]

WRITTEN NOTIFICATION: Plan of care: When reassessment, revision is required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the plan of care for a resident was revised when their bathing needs changed and the care set out in the plan was no longer necessary.

Rationale and Summary
A complaint was received regarding a resident's bathing schedule not being adhered to.

A review of the resident's current care plan specified they should receive baths at a certain frequency per week. A review of the bathing schedule posted in the bathing room and nursing office showed the resident should have received one fewer bath per week than what was specified in the plan of care.

A Personal Support Worker (PSW) confirmed that the number of baths the resident was currently receiving was the frequency detailed on the bathing schedule and acknowledged the frequency had

changed. The Administrator confirmed that the resident's care needs had changed and the previous bathing schedule was no longer necessary.

Interviews with a Registered Practical Nurse (RPN) and the Staff development, health and safety officer confirmed the current care plan was no longer reflective of the resident's care needs.

There was a risk of unclear direction and non-compliance with the plan of care when the care plan for the resident was not revised during a change of their care needs.

Sources: Care plan; bathing schedule; Interviews with a PSW, an RPN, the health and safety officer and the Administrator.

[741726]

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of the care set out in a resident's responsive behaviour plan of care was documented.

Rationale and Summary
Review of the current plan of care related to responsive behaviours on point click care for the resident indicated that the Dementia Observation System (DOS) tool was to be completed.

Review of the resident's DOS tool for a specified timeline indicated that on two out of five dates, one shift's documentation was omitted.

During an interview, an RPN stated that DOS tools were to be completed in full for five days. When the tool has not been completed, it makes it difficult to assess the resident's behaviours.

By not completing the Dementia Observation System (DOS) documentation, the information cannot be fully analyzed.

Sources: Review of the care plan, DOS tool and interview of a PSW and other staff.

[622]

WRITTEN NOTIFICATION: Requirements of program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (2) (a)

i. The licensee has failed to ensure that contact precautions were implemented for two residents according to the infection prevention and control programs required evidence-based policies and procedures.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is policy in place to limit the spread of infectious organisms, and that the policy is complied with. Also, in accordance with O. Reg. 79/10, s. 8 (1) (b), the licensee is required to ensure that there is policy in place to limit the spread of infectious organisms, and that the policy is complied with.

Review of the licensee's policy titled 'Guidelines for the Management of Methicillin Resistant Staphylococcus Aureus (MRSA)', indicated that all residents admitted to the long-term care home that are identified to be at high risk for MRSA will be treated as positive. They will be placed in a single room on contact precautions including set up of Personal Protective Equipment (PPE) and signage outside of the resident room until negative cultures are received.

Review of the two residents hard copy admission documentation indicated that both residents were diagnosed positive for MRSA.

Review of progress notes on point click care stated that one of the resident's was admitted to the long-term care home and contact precautions were started twelve days later. The second resident was admitted to the long-term care home and contact precautions were started six days later.

The Infection Prevention and Control (IPAC) Lead stated that both residents should have been placed on contact precautions on their date of admission if they were known to be positive for MRSA.

By not placing residents on contact precautions when they are positive for MRSA at the time of their admission, places other residents and staff at risk for contracting MRSA. The impact was unknown.

Sources: Review of resident admission records, the progress notes and interview with the IPAC Lead and

other staff.

[622]

ii. The licensee has failed to ensure that the infection prevention and control program evidence-based policies and procedures related to the implementation of contact precautions for a resident were complied with.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is policy in place to limit the spread of infectious organisms, and that the policy is complied with.

Review of APPENDIX C, titled: MRSA (Methicillin Resistant Staphylococcus Aureus) Protocol for Treatment, stated that MRSA protocol for treatment was to place the resident on contact precautions, set up Personal Protective Equipment (PPE) and signage outside of the resident room. Precautions may be discontinued after 3 negative sets of cultures taken 1 week apart, after discussion with the IPAC Officer. Monthly screening for 6 months is recommended following the clearing of MRSA.

The resident's room was observed and contact precautions were not in place as there were no precaution signs or Personal Protective Equipment (PPE) set up at their room. A review of the resident's current care plan on point click care indicated that the resident was diagnosed as being positive for MRSA.

Review of the resident's health records including the progress notes and laboratory swab results indicated that there were no records of three negative sets of MRSA culture reports taken one week apart or that the contact precautions were discontinued.

During separate interviews, a Housekeeper, two PSW's, and the Infection Prevention and Control (IPAC) Lead, all indicated that they were not aware that the resident had a positive diagnosis for MRSA. The IPAC Lead reviewed the resident's health records and stated that they did not understand why the contact precautions were not in place.

By not implementing contact precautions for residents who have a positive diagnosis for MRSA, places staff and residents at risk for contracting MRSA.

Sources: Observation of the resident's room, review of the resident's health records including progress notes, laboratory reports, the care plan, the licensee's policy, and interview of the IPAC Lead and other staff.

[622]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)

The licensee failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

Rationale and Summary
In accordance with s. 27 (1) (a) and (b), and s. 27 (3) of the Fixing Long-term Care Act, 2021 (the Act), the licensee must ensure that, every alleged, suspected or witnessed incident of neglect that the licensee knows of is reported to the Director as provided for in the regulations. In making a report to the Director under s. 27 (2) of the Act, the licensee must include all of the material outlined in Ontario Regulation 246/22, s. 112 (1). This is done by submitting a critical incident report using the critical incident system for reporting.

As defined in Ontario Regulation 246/22, “neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

It was alleged by an employee of the long-term care home that registered nursing staff were not completing and/or were falsifying required head injury routine assessments, specifically during one of the shifts. The employee alleged that on that shift, the head injury routine assessments had been falsified for six individual residents, including resident #017. The information provided was indicative of a possible pattern of inaction (failure to complete required assessments) that jeopardizes the health of one or more residents. Multiple members of the leadership team were made aware of the allegation.

As described in NC #020, the Inspector was provided with a photo - date and time stamped, demonstrating that entries made on the head injury routine record for resident #017 during the shift in question had been filled in, in advance, and pre-signed for. The entries made were indicative that the resident had refused the required assessments, though a review of video footage with the DOC showed that no member of registered nursing staff had actually entered the resident's room that shift.

According to the DOC, an RPN and a Registered Nurse (RN) had been working on the night in question,

with the RPN's signature having been found on the head injury routine record.

During an interview, the RN recalled that the same nurse, the RPN, had advised them to write "refused" or "sleeping" on any head injury routine records during night shifts, so as to avoid waking the resident. According to the RN, this direction was offered to them during training, approximately one year ago. At the same time, the RN reported that two night nurses - the RPN and a second RN, continue to indicate that resident's are sleeping or refusing the required head injury routine assessments during night shifts without any other explanatory notes to support their claims.

Multiple other cases in which head injury routines were not completed as required during night shifts were found over the course of the inspection (see NC #020).

The DOC was made aware of all of the above information gathered over the course of the inspection. However, the Inspector was unable to locate a relevant critical incident system report at any time related to the above described allegation and findings.

Sources: Review of multiple resident health care records, including those of resident #017, relevant head injury routine records, relevant photo and video records, and relevant information posted to an electronic bulletin board within Point Click Care, critical incident system records; and, interviews with staff, including an RN, the DOC, the Nursing Supervisor, the Deputy Administrator, and another employee of the long-term care home.

[655]

WRITTEN NOTIFICATION: Binding on licensees

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee failed to comply with the Minister’s Directive, COVID-19 Response Measures for Long-Term Care Homes (the Minister's Directive), effective August, 2022, regarding masking.

Rationale and Summary
In the Minister’s Directive, it was indicated that licensees were required to ensure that the masking requirements set out in the COVID-19 guidance document for Long-Term Care Homes in Ontario (the guidance document) were followed.

The guidance document described that all staff, students, and volunteers must wear a surgical mask for the entire duration of their shift indoors. It further indicated that staff must always remain two meters away from others when a mask is removed during their break, and that masks must not be removed in designated resident areas.

i. The licensee failed to comply with the Minister's Directive when masking requirements set out in the guidance document were not met on multiple dates during the inspection.

Rationale and Summary
On numerous occasions over the course of the inspection, staff members were observed without a mask, or wearing a mask in such a way that the staff member's mouth and/or nose remained exposed while they were within two meters of a resident in designated resident areas, including:

- A staff member was observed to have made physical contact with a resident in a resident common area,
- A staff member who was interacting with residents in a dining room,
- A PSW who was also interacting with residents in a dining room; and,
- A second PSW who was sitting in close proximity to a resident, singing, without a mask, in a resident common area. Several other residents were also seated in the area.

Failing to wear a mask in designated resident areas, and within two meters of a resident, poses a risk to all residents related to the potential for transmission of infectious disease.

Sources: Multiple observations of staff over the course of the inspection; interview with staff, including the Staff Development/Health & Safety Officer; and the Minister’s Directive: COVID-19 Response Measures for Long-Term Care Homes.

[655]

ii. The licensee failed to comply with the Minister's Directive when masking requirements set out in the guidance document were not met.

Rationale and Summary
A PSW was observed sitting on a nurse’s station counter and was facing outwards to the resident home area, within two meters of an RPN and a resident in a wheelchair. The PSW was talking and their mask was hanging by one ear loop from their left ear and not covering their face. The Inspector asked how the mask should be worn and the PSW subsequently replaced their mask on their face.

During an interview, the IPAC Lead stated that staff are to always wear surgical masks when inside the long-term care home and that the PSW should have been wearing their mask properly.

Not wearing a mask within two meters of a resident and staff, places the resident and staff at risk of disease transmission.

Sources: Observations of staff masking, interview with the IPAC Lead.

[622]

WRITTEN NOTIFICATION: Falls prevention and management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident fell, a post-fall assessment was conducted using a clinically appropriate assessment tool that is specifically designed for falls.

Rationale and Summary
The licensee's policy titled 'Falls Prevention and Management Program' indicated that when a resident has fallen, a fall assessment is completed under the risk management section in Point Click Care.

A progress note detailed that the resident reported they had a fall out of bed. A post-fall assessment under risk management was not created after the unwitnessed fall was reported to the RN. On the following shift, an RPN completed a head injury assessment related to the fall reported the previous shift. The RPN stated that a self-reported fall is recognized as a unwitnessed fall and all assessments in the licensee's falls prevention and management policy would be required to be completed.

The DOC stated the licensee's policy did not speak to a scenario where the resident self-reporting the fall is confused, however they reviewed the progress note from the unwitnessed fall and stated they would have completed a post-fall assessment in this scenario.

Failing to complete a post-fall assessment placed the resident at an increased risk of undetected injury.

Sources: Progress notes, risk management assessments, and interviews with the RPN and the DOC.

[756]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

The licensee has failed to ensure that their written policy related to nutritional care and dietary services was complied with.

Rationale and Summary
A resident sustained a burn during a dining service. A review of the daily food temperature log for the resident's home area showed temperatures were not recorded for this meal service, or for two other meal services.

During an interview with a Dietary Aide and the Supervisor of Nutrition Services, it was confirmed that the process was to record temperatures for each dish in the log book, at each dining service and at the point of service. The Supervisor of Nutrition Services further acknowledged the temperature log for the date of the initial burn did not have temperatures listed for the meal service, which is required, confirming this was not done according to policy.

There was a risk of harm to the resident when the written procedure in relation to food temperatures at point of service was not complied with.

Sources: Temperatures of Food at Point of Service Policy, Daily food temperature record, interviews with a Dietary Aide and Supervisor of Nutrition Services.

[741726]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with.

In accordance with section 5.3 under the Infection Prevention and Control (IPAC) Standard for Long-

Term Care Homes (April 2022), the licensee shall ensure that the IPAC program includes policies and procedures for the implementation of Routine Practices and Additional Precautions including cleaning and disinfection.

Rationale and Summary
The licensee's Infection Prevention and Control (IPAC) Policy titled 'A - Cleaning and Disinfecting/Sterilizing Medical Devices/Equipment', indicated that the cleaning and disinfection of the high touch surfaces was to be completed daily and more frequently when in outbreak. Documentation of the cleaning and disinfection of the high touch surfaces was to be completed on the appropriate cleaning schedule/tracking sheet.

The Covid Infection Control Measures documentation sheet that was implemented during a COVID-19 outbreak on a resident home area (RHA). Housekeeping staff were to document the cleaning and disinfection of the high touch surfaces twice daily during the COVID-19 outbreak. Review of the document indicated that four dates were documented during one month and there was no documentation for the following month.

Review of the housekeeping checklists indicated that the documentation of cleaning and disinfection of the high touch surfaces once daily when not in outbreak and twice daily when in outbreak was not included.

During an interview, the Support Services Supervisor stated that documentation for daily cleaning and disinfection of the high touch surfaces was not being completed when an RHA was not in outbreak.

Sources: Review of licensee's Infection Prevention and Control (IPAC) Policy 'A, COVID Infection Control Measures sheet', housekeeping checklist and Interview of the Support Services Manager and other staff.

[622]

WRITTEN NOTIFICATION: Dealing with complaints

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)

The licensee has failed to ensure that a documented record is kept in the home for each verbal or written complaint.

Rationale and Summary
A resident left the home prior to the substitute decision-maker (SDM) being notified and a verbal complaint was provided to a staff member.

A review of progress notes in Point Click Care (PCC) for that date revealed that the staff member took the concern and notified management by e-mail.

A request for the record of complaint was made to the Administrator, the Deputy Administrator, and the DOC. During an interview with the Administrator and the Deputy Administrator, it was confirmed that there was no evidence that a record of the complaint had been maintained.

By not retaining a record of written or verbal complaints involving the care of a resident, it is unclear if actions were taken to resolve the concern. This could impede the health, safety, and well-being of the residents.

Sources: PCC Progress Notes for a resident, interviews and request for information with the DOC, the Deputy Administrator, and the Administrator.

[741726]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 3.

The licensee failed to ensure that the Director was informed of a missing or unaccounted for controlled substance, no later than one business day after the occurrence of the incident.

Rationale and Summary
It was alleged by an employee of the long-term care home that the emergency drug supply contained a low supply of a controlled substance, and that it was unaccounted for. According to the employee, the incident had not been reported to the Director under the Fixing Long-term Care Act, 2021 (FLTCA, 2021). The employee further alleged that there had been a shortage of controlled substances available in the emergency drug supply for several months.

The Inspector reviewed audits of the inventory for the emergency drug supply and noted shortages in various controlled substances. The identified shortages were confirmed by the PSW Supervisor/RPN.

Over the course of the inspection, additional information was gathered which supported the possibility of unaccounted for controlled substances. Refer to NC #021 for additional information.

At the time of the inspection, the above-described allegation concerning missing or unaccounted for controlled substances from the emergency drug supply maintained by the home had not been investigated, or reported to the Director under FLTCA, 2021.

Sources: Staff interviews, including interviews with the PSW Supervisor/RPN, an RN, the Staff Development/Health & Safety Officer, the DOC, and representatives of the pharmacy service provider, including a Clinical Pharmacist Consultant, a Pharmacist, and a Pharmacy Manager; a review of relevant policies including the Emergency Medication Box Procedure and the Emergency Medication Box Procedure Using Point Click Care; and, a review of other related records including drug shipment records, emergency box re-order sheets, emergency medication box lists, and related email correspondence.

[655]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 5.

The licensee failed to ensure that the Director was informed of a medication incident in respect of which a resident was taken to hospital no later than one business day after the occurrence of the incident.

Rationale and Summary
According to a medication incident report, a resident received a higher dose of a medication than what was prescribed according to an RPN. On the medication incident report, the incident was assigned a severity level of "category F", meaning that it may have contributed to or resulted in temporary harm, and required initial or prolonged hospitalization. The resident's hospitalization was identified as an intervention on the medication incident report.

During an interview, the RPN who completed the above-referenced medication incident report indicated that the medication incident had potential to negatively impact the resident. The RPN indicated that the resident had a fall one day after the incident occurred, and was subsequently hospitalized. At the same time, the RPN indicated that a concern had been raised related to the resident's level of sedation, and

that for that reason, they had identified the resident's post-fall hospitalization as being relevant to the medication incident.

At the time that the inspection was completed, there was no record of a critical incident report having been submitted to the Director under the Fixing Long-term Care Act (FLTCA), 2021.

Sources: Review of resident's health care records including progress notes, prescriber (physician) orders, electronic medication administration records (eMAR), a review of a related medication incident report, and relevant medication shipment records from the pharmacy service provider; interviews with staff including, four RPN's and the DOC.

[655]

WRITTEN NOTIFICATION: Medication Management System

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

i. The licensee failed to ensure that written policies and protocols developed for the medication management system were implemented related to medication reconciliation.

Specifically, staff failed to implement the following policies:

- Medication Reconciliation - Long-term Care Homes; and,
- Processing Physician Medication Reviews.

Rationale and Summary
In follow-up to compliance order (CO) #003 from 2022_1551_0002, the Inspector reviewed the steps taken to complete medication reconciliation for a resident upon readmission to the long-term care home, post-hospitalization.

The Inspector reviewed the "Medication Reconciliation and Admission Order" form completed for the resident at the time and found that the signatures were missing for the first and second nurse checks on three out of five pages of the form. In addition: only one source document was identified, any remaining spaces after the last entry had not been crossed out; and, directions to "continue", "discontinue", or "hold" were not clearly identified for each listed order with the prescribers initials. For example, an order for a medication included conflicting directions to both "continue" and to "discontinue" the order,

without any prescriber initials present to distinguish which action was intended.

During an interview, an RPN, who was present when the resident returned to the long-term care home from hospital indicated that they had assisted in preparing the above-described medication reconciliation form. At the same time, the RPN indicated that they were not sure whether the licensee's policy would require a preparatory independent check of the prepared medication reconciliation form (i.e. a second preparing nurse signature).

However, a preparatory independent check (two separate preparing nurse checks) was described in the policy; and was confirmed to be the expectation by the RAI-Admissions Coordinator/RPN, who had a role in overseeing the process of resident readmissions.

During an interview, the RAI-Admissions Coordinator/RPN, expressed that the second preparing nurse signature was not being consistently obtained on medication reconciliation forms, primarily due to lack of staff availability; and/or, that the prescriber will authorize the orders listed on the prepared medication reconciliation form before the second preparing nurse has had a chance to review. Moreover, it was indicated that the requirement of the preparatory independent double check was not clearly set out within the existing policies.

Similar concerns had been identified when CO #003 was issued in report 2022_1551_0002. As indicated in NC #001, CO #003 was not complied with.

Sources: Relevant policies including Medication Reconciliation - Long-term Care Homes and Processing Physician Medication Reviews, a pharmacy audit related to medication reconciliation, health care records belonging to the resident, including relevant hospital records and the "Medication Reconciliation and Admission Order" form, records related to actions taken to address compliance orders issued in 2022-1551-0003; and interviews with staff, including an RPN, the the RAI-Admissions Coordinator/RPN, and a Clinical Pharmacy Consultant.

[655]

ii. The licensee has failed to ensure that their written policy related to medication management was complied with.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that their written policy related to medication management for a resident is complied with. Specifically, staff did not comply with the Ordering and Receiving Medication policy which states the nurse must reorder PRN (as needed) medications when additional supply is required.

Rationale and Summary
A record review of the resident's electronic medical administration record (eMAR) showed an order for a medication to be administered as needed. Progress Notes from a specific date showed the Substitute Decision Maker (SDM) for the resident purchased and brought in a supply of this prescribed medication and administered it to the resident. A PSW confirmed that when the resident requested this medication on the weekend prior, there was none available, and the POA was requested to bring some into the home.

During a review of the drug record book utilized for reordering medications, there was no evidence that the medication had been ordered from pharmacy during that period. An RPN confirmed that there was no supply of the medication within the home, and the process for reordering medication is to place a sticker in the drug reorder binder and fax the page to the pharmacy for a refill.

According to the quarterly physician medication review, the last date the medication was filled by CareRx pharmacy was months prior which was confirmed in an interview with the Pharmacist.

Failure to ensure medications, which are required on an as needed basis, are reordered in a timely manner could result in a delay in treatment and may place the resident at risk of adverse health effects.

Sources: Ordering and receiving Medication policy; Drug Record Book; Quarterly Physician Medication Review; progress notes, and eMAR for the resident; Interviews with a PSW, an RPN, and a Pharmacist.

[741726]

WRITTEN NOTIFICATION: Administration of Drugs

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)

The licensee has failed to ensure that no drug is used by or administered to a resident unless the drug has been prescribed for the resident.

Rationale and Summary
Review of a CareRx medication incident report indicated that an RPN administered one resident's medications to another resident. The RPN confirmed that this incident occurred.

By administering medication to a resident that has not been ordered for them places the resident at risk of injury. There was no harm to the resident because of this incident.

Sources: Review of the CareRx medication incident report and interview with an RPN.

[622]

WRITTEN NOTIFICATION: Administration of drugs

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
i. The licensee failed to ensure that a drug was administered to the resident in accordance with the directions for use specified by the prescriber when they were given a dose twice the prescribed dosage on three dates.

The resident's electronic medication administration record (eMAR) was reviewed for one month and it was noted that the prescription for the drug ordered two months prior had not yet been removed from the resident's eMAR. It was also noted that a second order for the same drug and dosage had been added to the same eMAR during the month of review, causing a duplicate order.

An RPN recalled that two doses of this drug had been available for administration to the resident during the medication pass, in the resident's individual medication supply, for a period of time.

Medication shipment reports reviewed during the inspection were also indicative that the amount of the drug that had been delivered to the long-term care home for the resident during the month of review was of sufficient quantity to fulfill both (duplicate) orders; and, the entries made by staff on the resident's eMAR were indicative that both drug doses had been administered to the resident on three separate days during a one-week period.

According to documentation in the resident's health care records, the resident's SDM had voiced concerns related to the resident's level of sedation after the dose of the drug had been increased. Other records reviewed stated that the resident had had multiple falls since the dose of the drug had been

increased.

ii. The licensee failed to ensure that a drug was administered to the resident in accordance with the directions for use specified by the prescriber.

The resident's eMAR was reviewed and it was noted that the drug order to decrease the dose had not yet been added to the resident's eMAR.

According to a medication incident report, the order for the drug had not been added to the resident's eMAR until a date three weeks into the month of review. In the same medication incident report, it was stated that prior to this date, an agency nurse had administered the drug at the previous dosage to the resident instead of the more recently prescribed lowered dose.

During an interview, the RPN who completed the above-described medication incident report confirmed that the agency nurse administered the higher dose of the drug to the resident on the specified date. The RPN indicated that the resident was subsequently hospitalized after sustaining an injury as a result of a fall. The RPN identified the medication error as a potentially contributing factor of the resident's fall and hospitalization.

As a result of this non-compliance, the resident was at risk of experiencing adverse effects of a medication error, including increased sedation and falls. The resident did in fact fall multiple times in the month of the error and was hospitalized after sustaining an injury.

Sources: Review of the resident's health care records including progress notes, prescriber (physician) orders, electronic medication administration records (eMAR), a review of a related medication incident report, and relevant medication shipment records from the pharmacy service provider; interviews with staff including four RPN's and the DOC.

[655]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)

The licensee failed to ensure that the medication incidents involving a resident were reported to the resident's substitute decision-maker (SDM); and, failed to ensure that a medication incident involving a

resident and the pharmacy service provider was reported to the pharmacy service provider.

Rationale and Summary
As described in NC #015 the licensee failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber:

i. The licensee failed to ensure that the above-listed medication incidents involving the resident were reported to the resident's SDM.

In a progress note, an RPN wrote that they had been informed by a nursing supervisor that the resident had received excess of a drug, with two doses of the drug ordered approximately two months apart. In the same note, the RPN wrote that the physician had been made aware and had requested that the resident's SDM not be notified of the incident until the physician had spoken with the DOC. Approximately 13 days later, during an interview, the RPN confirmed that they had suspected that the resident had received excess of the drug, as described in the note, but that the resident's SDM had not yet been notified. At the same time, the RPN indicated that they had not completed a medication incident report for this particular incident because it was their belief that another RPN had completed the required report.

During an interview, the other RPN indicated that they had completed a medication incident report related specifically to the above-noted incident but had not looked at the concern. During the same interview, the RPN indicated that it was their belief that the first RPN had notified the resident's family of the medication incident described in the completed medication incident report, though they had not.

Four weeks after both of the above described errors had been identified, the DOC indicated that while they had initially notified the SDM that a concern related to the drug was being looked at, they had not notified the resident's SDM of any actual medication error.

ii. The licensee failed to ensure that a medication incident involving the resident was reported to the pharmacy service provider.

During an interview, an RPN indicated that they had completed a medication incident report related specifically to the above-noted incident; but had not looked at the concern related to the incident described by the other RPN.

According to nursing staff, the pharmacy service provider is automatically notified of a medication incident when a medication incident report is completed. However, it was determined over the course of the inspection that no medication incident report had been completed when it was suspected that

the resident had, or potentially had, received a double dose of the drug during the medication pass on thirteen dates.

In addition, a third RPN indicated that they had previously been aware of a duplicate order of the drug in the resident's eMAR in the month of review. The RPN also recalled that the additional dose of the drug had been available in the resident's medication supply for administration at the time. However, there was no indication that the RPN had notified the pharmacy service provider when the discrepancy was identified, nor that they initiated a medication incident report.

Failing to notify the resident's SDM of a medication incident prevents the SDM from being fully informed and therefore from effectively advocating for the resident. Failing to notify the pharmacy service provider of a medication incident which involved the pharmacy may have prevented the discrepancy from being corrected in a timely manner, posing a risk to the resident's health related to the risk of a recurring medication error.

Sources: Review of the resident's health care records including progress notes, physician orders, eMAR, a review of a related medication incident report, and relevant medication shipment records from the pharmacy service provider; interviews with staff including four RPN's and the DOC.

[655]

WRITTEN NOTIFICATION: Director of Nursing and Personal Care

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 250 (1) 5.

The licensee has failed to ensure the Director of Nursing worked regularly in that position, on site, for at least 35 hours per week.

Rationale and Summary
During interviews with the Administrator and the Deputy Administrator, it was confirmed there was a period of time where the Nurse Practitioner (NP) was also the acting DOC. It was also confirmed that the NP was at no point a dedicated DOC and was always working two positions at the same time.

A job description for the role of NP was reviewed and showed extensive clinical responsibilities with reporting responsibility directly to the Director of Nursing. An employment contract was also reviewed for the role of NP which specified hours of work being a minimum of 32 hours up to a maximum of 64

hours bi-weekly plus four hours for on-call every second week.

An email received from the General Manager of Long-Term Care confirms the NP would begin DOC duties on a part time basis for a three-month period of time. A review of this email and the timesheet for the NP/DOC showed that during a one-month period specifically, the NP/DOC worked a total of 76 hours biweekly. Of the 76 hours worked, eight hours biweekly was noted to be compensation for the additional DOC duties.

Interviews with the Administrator confirmed the NP/DOC was compensated eight hours biweekly for their additional DOC duties.

When there is no consistent Director of Care available, clinical oversight and staff development may become compromised, placing the health, safety, and wellbeing of residents at risk.

Sources: NP Job Description; Email from the General Manager of Long-Term Care; Employee Timesheet for the NP/DOC; Interviews with the Administrator and the Deputy Administrator.

[741726]

(A1)
The following non-compliance(s) has been amended: NC #018

COMPLIANCE ORDER CO #001 When reassessment, revision is required

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

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

1) Develop a falls prevention audit tool to review each fall incident, the possible cause for the fall, what interventions were in place prior to the fall and the revision of the falls plan of care after the fall.

2) Complete the falls prevention audit tool for three separate resident falls weekly over a period of four weeks, (Must include falls for the specified resident, when they have fallen). Analyze the three falls prevention audit tools weekly to ensure that the audit tools have been completed, and includes the possible cause for the fall, what interventions were in place prior to the fall and the revision of the falls

plan of care after the fall, when interventions have not been effective.

3) Keep a documented record of all falls prevention audits and their analysis that have been completed during the four week period.

Grounds
The licensee has failed to ensure that a resident was reassessed and the plan of care revised when the care set out in the fall prevention plan has not been effective.

Rationale and Summary
Review of the progress notes on point click care indicated that the resident fell five times during a four day period and fell again three days later and sustained an injury.

Review of the resident's plan of care including the care plan, progress notes, physician orders, fall risk assessments, RAI, MDS assessments and the risk management documentation on point click care, indicated that there were no revisions made to the fall prevention plan of care as a result of the five falls the resident sustained during the four day period.

During an interview, an RN reviewed documentation in the resident's electronic health records and noted that there were no revisions made to the resident's fall prevention plan of care until after they fell and sustained an injury.

Failing to revise a resident's fall prevention plan of care when the plan had been ineffective placed the resident at risk for further falls.

Sources: Review of the progress notes, physician orders, fall risk assessments, RAI, MDS assessments, the risk management documentation on point click care and interview of an RN and other staff.

[622]

This order must be complied with by November 15, 2023

(A1)
The following non-compliance(s) has been amended: NC #019

COMPLIANCE ORDER CO #002 Staffing Plan

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 35 (2)

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

1) Develop a written staffing plan for the organized program of nursing and personal support services.

The written staffing plan must:

a) provide for a staffing mix that is consistent with residents assessed care and safety needs,
b) set out the organization and scheduling of staff shifts; and,
c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident.

2) Develop and implement a written back-up plan for nursing and personal care staffing that addresses situations when staff are not able to come to work for the night shift. The back up plan shall take in account the resident's level of care and risk associated to each resident home area during the night shift.

3) All nursing managers and any other manager who performs the on-call manager role, scheduling staff, and registered nursing staff shall be educated on the written staffing plan, including the back-up staffing plan for the night shift.

A written record of all staff educated must be kept until the Ministry of Long-Term Care has determined the licensee has complied with this order.

Grounds
i. The licensee has failed to ensure that there was a written staffing plan for the organized program of nursing and personal support services and a back-up plan for nursing and personal care staffing that addressed when staff could not come to work on the night shift.

Rationale and Summary
The Administrator identified the Deputy Administrator as the lead of the staffing program. Upon request, the Deputy Administrator was unable to provide a written staffing plan for the organized program of nursing and personal support services.

In regard to a back-up staffing plan for the night shift, the Deputy Administrator provided a memo titled 'Staff Reallocation Process/Guide with unreplaced call ins'. This document provided a back-up staffing plan for the day and evening shift when staff could not come to work but did not provide a back-up plan for the night shift. The Deputy Administrator provided a second document titled 'PSW Distribution List', however they identified that at the time of the interview the document had not yet been implemented and there were no other documents that spoke to a back-up staffing plan.

According to a Scheduler, there was an on-deck PSW position on the night shift. However, they identified that if there is no staff member scheduled to work in that position, they did not try find a replacement unless there were fewer than three registered nursing staff scheduled to work that shift. The Scheduler identified they were provided verbal direction for this scheduling practice and did not have a written document directing this. The DOC clarified that the direction was that the on-deck PSW should always be scheduled on the night shift but they were not aware of a document that stated this.

Failing to have a written staffing plan in place, as well as a back-up plan for nursing and personal care staff that cannot come to work on the night shift, there was an increased risk to resident care and safety.

Sources: Memo titled Staff Reallocation Process/Guide with unreplaced call ins, PSW Distribution List, interviews with the Administrator, the Deputy Administrator, the DOC and the Scheduler.

[756]

ii. The licensee has failed to ensure that the staffing plan included a back-up plan for nursing and personal care staffing that addressed situations when staff could not come to work during the night shift.

Rationale and Summary
A memo titled, 'Staff Reallocation Process/Guide with unreplaced call ins' was presented to inspector #756 by the Deputy Administrator as the back-up staffing plan, however it did not contain processes to address situations when staff could not come to work during the night shift.

Inspector #622 did not receive any other written documents that addressed situations when the staff could not come to work during the night shift.

During an interview, the Deputy Administrator stated that there was no written back up plan for when the night shift was short staffed and it was up to the registered staff to arrange the staff and assist in care as needed.

Failing to have a written back up staffing plan for the night shift that addressed situations when staff could not come to work placed the residents care and safety at risk.

Sources: Review of a memo titled, 'Staff Reallocation Process/Guide with unreplaced call ins' and interview with the Deputy Administrator.

[622]

This order must be complied with by November 15, 2023

(A1)
The following non-compliance(s) has been amended: NC #020

COMPLIANCE ORDER CO #003 Falls prevention and management program

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

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

1) Provide all registered nursing staff with education on the licensee's fall prevention and management policies. This education must include when to complete a fall risk assessment tool, when to review a resident's drug regime in the context of falls prevention, restorative care approaches and the use of assistive devices, and when to complete a referral to a physiotherapist.

2) Immediately ensure that the specified RPN and RN are provided with education related to the requirements of completing head injury routine assessments, including on night shifts and/or when a resident is sleeping; and,

3) Ensure that all head injury routine assessments are completed for the four specified resident's, when required.

To ensure that required head injury routine assessments are being completed during the night shift, the licensee shall:

4) Develop and implement monitoring and remedial processes as follows:

a) Develop and complete a weekly audit to ensure adherence to the licensee's head injury routine protocol by registered nursing staff on the night shift. The weekly audit will be completed on all resident home areas for a period of four weeks; and,
b) The licensee shall ensure that relevant corrective action is taken if deviations from the established protocol by staff are identified.

A written record must be kept of everything required under step (1), (2), (3), and (4) of this compliance order, until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

Grounds
The licensee failed to ensure that when four resident's fell, the licensee's fall prevention and management policy was complied with.

In accordance with Ontario Regulation 246/22 (Regulation), s. 11 (1) (b), and 53 (1) 1, the licensee was required to have a falls prevention and management program, and to ensure that the program was complied with.

1) Specifically, the licensee failed to comply with the falls prevention and management program policy titled "Falls Prevention and Management Program". In the policy, it was indicated that the post-fall assessment was to include completion of a head injury routine whenever a resident falls and hits their head - or, is suspected of hitting their head - including when a resident has an unwitnessed fall.

i. The licensee failed to ensure that when a resident fell, the licensee's fall prevention and management policy was complied with in regards to head injury assessments.

Rationale and Summary
A progress note detailed that the resident reported they had an unwitnessed fall out of bed. A head injury routine was not initiated at the time of the reported fall and an RPN initiated a head injury routine on the following shift. When interviewed, the RPN stated this assessment was initiated as it is required for unwitnessed falls.

The resident experienced four further falls later in the same month. A head injury routine was initiated at the time of the falls, however the head injury assessments required at a specific time on the same day and at a specific time the following day, were not completed. The DOC confirmed that each timed assessment on the head injury routine form was to be completed.

As a result of the head injury routine not initiated at the time of the first fall, and the head injury routine assessments not completed at two specific times for the four further falls, the resident was at increased risk of undetected injury.

Sources: Progress notes, Head Injury Routine records, risk management assessments, and interviews with an RPN and the DOC.

[756]

ii. The licensee failed to ensure that when a resident fell, the licensee's fall prevention and management policy was complied with in regards to head injury assessments.

Rationale and Summary
A resident was identified by the complainant as a resident of concern due to their history of injury.

Over the course of the inspection, it was determined that the resident had been hospitalized and was found to have an injury which required surgical intervention. According to related hospital records, the resident allegedly had multiple falls during two months prior to the hospitalization where they sustained injury. In the hospital records, it was specifically indicated that the resident had had a fall on a specific date during the month prior to the hospitalization, which was substantiated in the progress notes.

The head injury routine record was reviewed and was initiated for the resident post-fall on the same day. The head injury routine record was found to be incomplete, with entries for three timed assessments left mostly blank. There were no entries in the progress notes overnight to indicate that the head injury routine had been completed as required, and no indication that the resident had refused the required assessments.

In addition to the above, the head injury routine records for the resident's more recent falls were reviewed. In several entries associated with required night shift head injury routine assessments, there was no assessment data entered. Rather, it was indicated that the resident was "sleeping".

According to the DOC, however, when a resident has been place on a head injury routine, registered nursing staff are expected to wake a sleeping resident in order to complete the required assessment(s).

The licensee failed to ensure that when the resident fell, the head injury routines were completed as required. As a result of this non-compliance, the resident's health was at risk related to the potential for an unidentified head injury.

Sources: Resident health care records, including progress notes, head injury routine records, and relevant hospital records; interviews staff including an RN and other members of registered nursing staff, the DOC, and another employee of the long-term care home.

[655]

iii. The licensee failed to ensure that when a resident fell, the licensee's fall prevention and management policy was complied with in regards to head injury assessments.

Rationale and Summary
According to the DOC, the resident fell and a head injury routine would have been required on the following shifts.

According to the documentation on the relevant head injury routine record, a head injury routine had been initiated for the resident at the time of the fall. However, there were no entries on the head injury routine record for the specified shifts on two following dates.

With the DOC, video footage for the shifts identified was reviewed. There was no indication that any member of registered nursing staff had entered the room of the resident on the shifts in question, in order to complete the required head injury routine assessments for the resident. The DOC confirmed the same.

As such, the licensee failed to ensure that the required post-fall assessment - specifically, the head injury routine, was completed for the resident on two shifts. This non-compliance posed a risk to the health of the resident related to the potential for an unidentified head injury post-fall.

Sources: A review of resident health care records, including head injury routines; review of the policy titled "Falls Prevention and Management Program"; review of relevant video footage; and, interviews with staff, including a PSW, an RN and other members of registered nursing staff, and the DOC.

[655]

iv. The licensee failed to ensure that when a resident fell, the licensee's fall prevention and management policy was complied with in regards to head injury assessments.

Rationale and Summary
Inspector #655 was provided with a photo - date and time stamped. The photo showed that the

resident's head injury routine record had been filled in for two future timed assessments on the same shift, in advance; and had been signed for. The pre-signed entries stated that the resident had "refused" the required head injury routine assessments. The same response ("refused") had been entered for an earlier assessment as well. During the inspection, the Inspector confirmed that the hard copy head injury routine record for the resident, completed on the specified two dates, did include the same responses as those depicted in the photo.

With the DOC, relevant video footage was reviewed. It was found that no member of registered nursing staff had entered the resident's room at any time to conduct the required head injury routine assessments during the shift in question. According to the DOC, an RPN and an RN had been working on the shift in question, with the RPN's signature having been found on the head injury routine record.

The RPN failed to complete the required post-fall assessment - specifically, the head injury routine, for the resident, during the shift on a specified date.

By not completing the required post-fall head injury routine, the resident's health was at risk related to the potential for an unidentified head injury.

Sources: A review of resident health care records, including progress notes, post-fall assessments, and head injury routine
records, relevant photo and video records, and relevant information posted to an electronic bulletin board within Point Click Care; interviews with staff, including: an RN, the DOC, and another employee of the long-term care home.

[655]

v. The licensee failed to ensure that when a resident fell, the licensee's fall prevention and management policy was complied with in regards to head injury assessments.

Rationale and Summary
According to entries made in the resident's progress notes, the resident had unwitnessed falls on two dates.

The head injury routine records related to each of the above-noted falls were reviewed.

- On the head injury routine record initiated at the time of the first fall, there were five entries associated with five separate assessment times which stated that the resident was "sleeping" at the time of the required assessment; and, there was no entry made at all for a shift two days later;

- On the head injury routine record initiated for the second fall, entries made for three timed assessments each read "sleeping" or "refused". There were no entries made at all for two shifts on two later dates.

At the same time, however, the DOC stated that nursing staff would be expected to wake a resident if a head injury routine assessment was required when they were sleeping; and that it was not appropriate to simply indicate on the record that the resident was "sleeping" at the time.

The licensee failed to ensure that the required post-fall assessments - specifically, the head injury routines, were completed for the resident after they fell on two dates. This posed a risk to the health of the resident related to the potential for an unidentified head injury post-fall.

Sources: Review of resident health records, including progress notes and relevant head injury routine records; and interviews with the DOC and another employee of the long-term care home.

[655]

2) The licensee failed to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls for a resident, including the monitoring of the resident, the review of the resident's drug regimes, and the implementation of restorative care approaches and the use of assistive aids.

Rationale and Summary
In accordance with Ontario Regulation 246/22 (Regulation), s. 11 (1) (b), and 53 (1) 1, the licensee was required to have a falls prevention and management program, and to ensure that the program was complied with. Further, in accordance with Regulation s. 54 (1), the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, and the implementation of restorative care approaches.

Specifically, the licensee failed to ensure that the falls prevention and management program provided for strategies to reduce or mitigate the falls of the resident, in the following ways:

i. The resident was not monitored for fall risk using the fall risk assessment tool, in accordance with the licensee's policy,
ii. The resident's drug regime was not reviewed post-fall, until after the resident experienced multiple falls following the start of a new medication; and,
iii. Restorative care approaches and the use of assistive aids were not implemented for the resident

when their status changed.

According to the program policy titled "Falls Prevention and Management Program", when a resident experiences a change in their condition, fall risk and physiotherapy assessments are to be completed. It further states that residents who have a change in condition, balance or gait; who are starting a new medication, or who have fallen or had a cluster of falls within the last three months would be considered at risk for falls.

According to the records reviewed, a fall risk assessment was completed for the resident on a specified date. In that assessment, the resident was noted to have a normal gait, and to be ambulating independently without the use of ambulatory aids. The next fall risk assessment was completed three weeks later. However, changes in the resident's condition, relevant to fall risk, were noted before that time:

- During interviews, staff reported that changes had been observed in the resident's gait. This was observed by the Inspector at which time the resident had been observed to also require the assistance of two staff members for ambulation and transfers; though, shortly thereafter the resident was observed to be ambulating independently with difficulty and without the use of an assistive device.

- According to records reviewed, one of the resident's medication was increased in frequency. The order directed staff to monitor the resident for sedation, increased falls, and side effects. The resident was found to have had multiple falls since the medication change.

On review of the resident's health care records, there was no indication that the resident had been assessed by physiotherapy despite the above described changes and noted increase in falls. On review of the post-fall assessments (risk management incident reports) completed for the resident, the change in medication had not been identified as a potentially contributing factor to any of the falls that occurred during the specified month.

During interviews, information provided by registered nursing staff was indicative that staff were not familiar with the relevant aspects of the falls prevention and management program, such as when to use the fall risk assessment tool, processes for reviewing a resident's drug regime in the context of falls prevention, or ensuring that restorative care approaches and the use of assistive devices aids were implemented when required, such as through referral to a physiotherapist.

In addition, the RAI Coordinator indicated that while it was not within their typical role to complete required fall risk assessments, they had done so for this resident on two dates because they were otherwise not being completed by registered nursing staff when required. According to the RAI

Coordinator, fall risk assessments were not consistently done when required in the home. The RAI Coordinator also flagged a concern related to the resident's medications in the context of falls prevention, having further expressed concern that there had been a lack of monitoring of the resident after a medication change.

The licensee failed to ensure that the falls prevention and management program effectively provided for strategies to reduce or mitigate the falls of the resident when staff failed to comply with the program policy titled "Falls Prevention and Management Program", related to the use of the fall risk assessment tool, review of the resident's drug regime in the context of falls preventions, and delayed referral and therefore assessment by a physiotherapist.

As a result of this non-compliance, the resident was at risk for recurrent falls. The resident did fall multiple times, with one fall resulting in an injury.

Sources: Resident health care records including progress notes, fall risk assessments, post-fall assessments (risk management incident reports), physician orders, physiotherapy assessments and referrals, related email communication, and the policy titled "Falls Prevention and Management Program"; and interviews with staff including two PSW's, two RPN's, an RN, and the Physiotherapist.

[655]

This order must be complied with by November 15, 2023

(A1)
The following non-compliance(s) has been amended: NC #021

COMPLIANCE ORDER CO #004 Emergency drug supply

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 132 (b)

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

1) Immediately initiate an investigation into the alleged incident of missing or unaccounted for controlled substances from the emergency drug supply maintained by the long-term care home; and,

2) Ensure that a report is made in writing to the Director under the Fixing Long-term Care Act, 2021, as required by s. 115 (5) of Ontario Regulation 246/22, related to the incident and outcome of the investigation.

3) Ensure that all members of registered nursing staff who can access the emergency drug supply, and/or who are responsible for replacing inventory in the emergency drug supply, receive training on the licensee's policies and procedures related to the use of the emergency drug supply; and,

4) Develop and implement monitoring and remedial processes as follows:

a) Develop and complete a weekly audit to determine adherence to the licensee's emergency drug supply policies and protocols by registered nursing staff. The audit will be completed for a period of four weeks; and,
b) The licensee shall ensure that relevant corrective action is taken if deviations from the established policies and protocols by staff are identified.

A written record must be kept of everything required under step (1), (2), (3), and (4) of this compliance order, until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

Grounds
i. The licensee failed to ensure that the written policies and procedures for reordering drugs, access to the emergency drug supply (the supply), use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply were complied with.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure the policies related to the emergency drug supply were complied with. Specifically, the licensee failed to comply with the policy titled "Management of Narcotic and Controlled Drugs".

Rationale and Summary
In the above-noted policy, it was indicated that when a controlled substance, such as a narcotic, is missing, a medication incident report is to be completed and the Director of Care is to initiate an investigation. It is further indicated that other parties, such as a professional college and/or police, would also be notified depending on jurisdictional legislative requirements and directives.

It was alleged by an employee of the long-term care home (the home) that the supply maintained by the home contained a low supply of a controlled substance at the time of the inspection; and, that it was unaccounted for. The employee further alleged that there had been a shortage of controlled substances

available in the supply for several months; and that the pharmacy service provider was unable to refill it because they did not know which resident it should be billed to.

Audits of the inventory for the supply were reviewed and shortages were noted in various controlled substances. The identified shortages were confirmed by the PSW Supervisor/RPN.

Over the course of the inspection, the Staff Development/Health and Safety Officer and the PSW Supervisor/RPN had each been identified as individuals who had investigated the concern.

However, the Staff Development/Health and Safety Officer denied having investigated any concern related to potentially missing or unaccounted for controlled substances from the emergency drug supply at any time. The PSW Supervisor/RPN could not confirm why the supply of any controlled substances in the emergency drug supply was low with any certainty and clarified that they had not specifically investigated the possibility of there being missing or unaccounted for controlled substances from the supply at any time.

Other information gathered over the course of the inspection supported the possibility of missing or unaccounted for controlled substances from the emergency drug supply maintained by the home:

- According to the PSW Supervisor/RPN, there was no supply of a specified controlled substance in the emergency drug supply at the time of the inspection.

- The pharmacy service provider also had identified a concern related to the possibility of missing or unaccounted for controlled substances from the emergency drug supply.

- An RN recalled performing an audit of the emergency drug supply inventory, and finding that the supply for various drugs, including controlled substances was low. The RN was not aware of any investigation into the low supply and indicated that they had assumed, at the time, that resident names had been identified in a prior order, and simply re-ordered the items without identifying a resident's name.

- A representative of the pharmacy service provider indicated that in two instances a drug from the emergency drug supply for a resident and re-ordered it the same day, the pharmacy billed for it and delivered the replacement supply. In both cases, however, there was no record of the drug having been signed-in/received on the emergency stock re-order sheet, as would be required, according to the PSW Supervisor/RPN.

Over the course of the inspection, the DOC was made aware that the Inspector was unable to confirm

whether or not controlled substances were missing or unaccounted for from the emergency drug supply, and that there had been no complete investigation done related to the concern. The DOC indicated that they were unable to initiate an investigation into the matter at the time of the inspection, though they would do so at a later date. Police had also not been notified of the concern and there was no indication that a related medication incident report had been initiated.

The failure to investigate and notify police, in accordance with the licensee's policy, posed a risk for undetected drug diversion - specifically, of controlled substances; and, of continued low supply of controlled substances in the emergency drug supply. This has the potential to impact any resident in the long-term care home who relies, or may rely, on the supply to meet their needs, including palliative care needs.

Sources: Staff interviews, including interviews with the PSW Supervisor/RPN, an RN, the Staff Development/Health & Safety Officer, the DOC, and representatives of the pharmacy service provider, including a Clinical Pharmacist Consultant, a Pharmacist, and a Pharmacy Manager; a review of relevant policies including the Emergency Medication Box Procedure and the Emergency Medication Box Procedure Using Point Click Care, the Management of Narcotic and Controlled Drugs; and, a review of other related records including drug shipment records, emergency box re-order sheets, emergency medication box lists, and related email correspondence.

[655]

ii. The licensee failed to ensure that the written policies related to the emergency drug supply, including the procedure for reordering drugs, and tracking and documentation with respect to the drugs maintained in the supply were implemented.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure the policies related to the emergency drug supply were complied with. Specifically, the licensee failed to comply with the policies titled 'Emergency Medication Box Procedure'; and, 'Emergency Medication Box Procedure Using Point Click Care'.

Rationale and Summary
It was alleged that staff at the long-term care home had not been following procedures related to the use of the emergency drug supply maintained by the long-term care home (the home), and that the stock of controlled substances in the supply was particularly low and allegedly unaccounted for.

The above-noted policies outlined the procedures for the re-ordering of drugs taken from the supply, for confirming receipt of the replacement drug for the supply, and for using the dedicated drug record book

for the supply. It is also indicated that the contents of the emergency drug supply is to be audited by registered nursing staff monthly, to ensure that all medications are present and not expired.

Over the course of the inspection, it was determined and confirmed by the PSW Supervisor/RPN, that procedures related to the use of the supply maintained by the home had not been implemented in the following ways:

a. Drugs, including controlled substances, taken from the supply were not always signed-out and/or re-ordered from pharmacy in accordance with required procedures,
b. Drugs, including controlled substances, received for the supply were not always signed-in in accordance with required procedures; and,
c. An internal audit of the supply inventory had not been completed on a monthly basis, as required.

Specifically:

a. Drugs, including controlled substances, taken from the supply were not always signed-out and/or re-ordered from pharmacy in accordance with required procedures.

During an interview with a representative of the pharmacy service provider, it was indicated that on a drug was used and re-ordered for a resident; but, the pharmacy was unable to refill it because they had not, at the time, been provided with complete information related to the use of the drug. For example, neither the quantity used, nor the quantity requested for re-order was identified on the re-order sheet, and the pharmacy had not yet received the relevant prescription for the identified resident. For these reasons, the use of the supply by the identified resident could not be verified at the time.

The Inspector was also provided with a copy of email communications involving the pharmacy service provider regarding a report from a registered nurse working at the long-term care home in the same month. In the email, it was indicated that the nurse had re-ordered numerous medications for the supply without identifying the resident for whom the requested drug was taken for. In the email, it was indicated that the request had been made this way after the nurse had found the supply to be "empty" at the time.

On review of emergency stock box re-order sheets, the Inspector found that, in addition to the above-described incident, numerous medications from the supply (including controlled substances) had been identified for re-order, but did not include the required information, such as for what resident the supply had been given to in the months for three months. These dates correspond to dates when the supply inventory had been audited by a member of registered nursing staff, as described below (see item c).

b. Drugs, including controlled substances, received for the supply were not always signed-in in accordance with required procedures.

The Inspector observed the emergency drug supply and reviewed relevant records, such as drug shipment records and emergency stock box re-order sheets, with the PSW Supervisor/RPN. At that time, the PSW Supervisor/RPN indicated that according to the records reviewed at the time, a delivery had been received for a drug, but it was not signed in, or recorded, as having been "received" on the emergency stock box re-order sheet, where they expected it to be recorded. The five ampules of the drug were found to be in the emergency box supply at the time, identified based on prescription numbers.

During an interview with a representative of the pharmacy service provider, it was indicated that when staff used a drug for two residents from the supply and re-ordered it the same day, the pharmacy billed for it and delivered the replacement supply. In both of these cases, however, there was no record of the drug having been signed-in/received on the emergency stock re-order sheet, as would be required, according to the PSW Supervisor/RPN.

According to a representative of the pharmacy service provider, when a controlled substance is taken from the supply for an identified resident, the drug will be replaced by the pharmacy under the resident's name provided there is an active prescription for use of the drug by that resident. The replacement supply would be delivered under the identified residents name, but with two separate allotments: one quantity for the identified resident's individual supply and the other being the quantity to be replaced into the emergency drug supply. According to the representative of the pharmacy service provider, it is the responsibility of registered nursing staff who receive the delivery to replace and sign-in the appropriate quantity into the emergency drug supply.

c. An internal audit of the supply inventory had not been completed on a monthly basis, as required.

According to the PSW Supervisor/RPN, the emergency box supply had been audited monthly for past three months; and, prior to that time, had been audited only three months during the previous year. Shortages in the inventory of the supply were found to have been recorded on the audit forms (Emergency Medication Box List) since at least the year prior. The shortages noted included shortages of controlled substances. At the time of the inspection, according to the PSW Supervisor/RPN, there was no supply of a specified controlled substance stocked.

During an interview with a representative of the pharmacy service provider, it was expressed that without a monthly audit of the supply inventory, it was difficult to keep track of or reconcile the supply.

The failure to implement policies related to the emergency drug supply posed a risk of drug diversion - particularly of controlled substances; and, overall low supply or expired supply, which has the potential to impact any resident who relies, or may rely, on the supply to meet their needs, including palliative care needs.

Sources: Staff interviews, including interviews with the PSW Supervisor/RPN, an RN, the Staff Development/Health & Safety Officer, the DOC, and representatives of the pharmacy service provider, including a Clinical Pharmacist Consultant, a Pharmacist, and the Pharmacy Manager; a review of relevant policies including the Emergency Medication Box Procedure and the Emergency Medication Box Procedure Using Point Click Care; and, a review of other related records including drug shipment records, emergency box re-order sheets, emergency medication box lists, and related email correspondence.

[655]

This order must be complied with by November 15, 2023

(A1)
The following non-compliance(s) has been amended: NC #022

COMPLIANCE ORDER CO #005 Medication incidents and adverse drug reactions

NC #022 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (a)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with O. Reg. 246/22, s. 147 (2) (a).

The licensee shall:

1) Review and analyze the medication incidents involving the specified resident to identify contributing factors and areas for process improvement, to prevent recurrence.

At a minimum, the review and analysis required under step (1) must:

a) Involve the pharmacy service provider; and,
b) Include consideration of the procedures for processing medication changes and new orders.

2) Ensure that when a discrepancy between a prescriber's original medication order and a medication order in a resident's electronic medication administration record is identified, immediate action is taken to resolve the discrepancy.

A written record must be kept of everything required under step (1) and (2) of this compliance order, until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

Grounds
The licensee failed to ensure that all medication incidents were documented, reviewed and analyzed.

Rationale and Summary
According to the policy titled "Medication Incident Reporting", a medication incident report is to be used for all medication incidents.

In the same policy, the term "medication incident" was defined as any preventable event that may cause or lead to inappropriate medication use or harm of resident. It is further stated that a medication incident may be related to various factors including professional practice, procedures and systems, and include order communication, dispensing, administration and monitoring.

Over the course of the inspection, the Inspector reviewed a medication incident report - a structured form that prompts the user to review and analyze a medication incident by directing them to consider the type of incident, stages involved in the incident, and to perform a root cause analysis by identifying possible contributing factors.

i. When a discrepancy was first identified related to a duplicate order of a drug having been included in a resident's eMAR, the medication incident was not documented, reviewed, or analyzed, as required by the licensee's policy.

According to the records reviewed during the inspection, the resident had been prescribed a drug as follows:

- The drug was initiated at a specified dose;
- Two months later the order for the specified drug was changed;
- Later the same month, the dosage for the specified drug was lowered.

The resident's electronic medication administration record (eMAR) was reviewed for the month the dosage changes occurred. At that time, it was noted that the above-listed drug order had not yet been removed from the resident's eMAR when a second order for the same dosage and administration time had been added to the same eMAR.

Notes entered in the resident's electronic medication administration record (eMAR) and progress notes by one or more members of registered nursing staff including an RPN, were indicative that one of the doses of the drug had been identified by the nurse as a "duplicate order" on four dates. However, on the remaining eight days during that time period, both doses of drug were marked as having been administered to the resident.

During an interview, the RPN confirmed that they had previously been aware of a duplicate order of the drug in the resident's eMAR during the specified month. The RPN also recalled that the additional dose of the drug had been available in the resident's medication supply for administration at the time. However, there was no indication that the RPN had clarified the order at the time, notified the pharmacy service provider when the discrepancy was identified, or that they initiated a medication incident report.

Rather, the duplicate order of the drug remained in the resident's eMAR until such time that the Inspector reported the concern to a member of the leadership team during the inspection.

ii. When the same discrepancy related to a duplicate order of the drug having been included in the resident's eMAR was identified and reported by the Inspector, the medication incident was not documented, reviewed, or analyzed, as required by the licensee's policy.

In a progress note dated the same day that the Inspector reported a concern related to the above-described duplicate order of a drug in the resident's eMAR to a member of the leadership team, an RPN wrote that they had been informed by a nursing supervisor that the resident had received excess of the drug, with the two doses ordered two months apart.

Approximately 13 days later, during an interview, the RPN confirmed that they had suspected that the resident had received excess of the drug, as described in the note. At the same time, the RPN indicated that they had not completed a medication incident report for this particular incident because it was their belief that another RPN had completed the required report, though they had not.

During interviews, both the DOC and the other RPN indicated that there had been no medication incident report completed for the above described medication incident, despite the established discrepancy in the resident's eMAR which, at a minimum, had had the potential to cause or lead to

inappropriate medication use or harm to the resident. According to both the DOC and the other RPN, a medication incident had not been completed for this particular incident because the second (duplicate) order of the drug had not actually been included in the resident's strip pack, or individual medication supply, and therefore was not available for administration at the time of the concern.

It was later determined that medication shipment reports provided by the pharmacy service provider were indicative that the amount of the drug that had been delivered to the long-term care home for the resident for a specified week was of sufficient quantity to fulfill both (duplicate) orders.

The medication incident was not documented, reviewed or analyzed using a medication incident report, as required by the licensee's policies when a discrepancy in the resident's eMAR related to duplicate orders of a drug was identified by a member of the registered nursing staff, or when it was later identified by the Inspector.

As a result of this non-compliance, the resident's health was at risk related to the potential for a recurring medication error and associated effects. According to the records reviewed, the resident did in fact experience an increase in sedation and frequent falls during the month in question.

Sources: Review of the resident's health care records including progress notes, physician orders, electronic medication administration records (eMAR), a review of a related medication incident report, relevant medication shipment records ("PACMED" reports) from the pharmacy service provider, and the policy titled "Medication Incident Reporting"; interviews with staff including four RPN's and the DOC.

[655]

This order must be complied with by November 15, 2023

(A1)
The following non-compliance(s) has been amended: NC #023

COMPLIANCE ORDER CO #006 Duty of licensee to comply with plan

NC #023 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with FLTCA, 2021, s. 6 (7).

The licensee shall:

1) Ensure that staff comply with the written plan of care for resident #001 related to bathing, and skin and wound care,

2) Ensure that staff comply with the written plan of care for resident #002 and #008, related to the implementation of falls prevention interventions - specifically, magnetic clip alarms or other alarm systems that may be used for the purpose of falls prevention; and,

3) Ensure that when any medication incident involving a resident occurs, any required post-incident monitoring is completed as specified in the resident's plan of care.

In ensuring the requirements under steps (1), (2), and (3), are met, the licensee shall:

4) Develop and complete a weekly audit of staff compliance with the written plan of care for each of the above-identified residents. This audit shall be completed for a period of four weeks.

5) Corrective action will be taken if deviations from the plan of care are identified.

A written record must be kept of everything required under this compliance order, until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

Grounds
The licensee failed to ensure that the care set out in the plan of care for resident #001, #002, #007, and #008, was provided to each resident as specified in the plan.

i. The licensee has failed to ensure that the care set out in the plan of care for resident #001, related to the frequency of bathing, was provided to them, as specified in the plan.

Rationale and Summary
A review of the resident’s care plan showed a revision to the bathing schedule, with an additional bath added. A review of Point of Care (POC) documentation, there were five days during a month, five days the following month, and three days two months later, where a bath was scheduled and not completed.

Interviews with a PSW and an RPN confirmed the bathing schedule for the resident for a period of time. An interview with the Staff development, health and safety officer confirmed a bath was not provided on the above-identified days.

There was risk to the resident's comfort and well-being, when the plan of care related to the frequency of bathing, as specified in the plan, was not complied with.

Sources: Care plan and revision history; POC Documentation Survey Report; Interviews with a PSW, an RPN, the Staff development, health and safety officer, and the Administrator.

[741726]

ii. The licensee has failed to ensure that the care set out in the plan of care, related to monitoring skin condition, was provided to resident #001 as specified in the plan.

Rationale and Summary
Staff were required to take weekly pictures of the resident's skin, for the purpose of monitoring and assessing the resident's skin condition, as ordered by the physician.

A review of the resident's health care records, including the skin and wound assessment, found two dates in the specified month; five dates in the following month, and three dates two months later in which there was no photograph recorded in the Skin and Wound assessment module, within Point Click Care (PCC).

During interviews, two RPN's confirmed that there should have been a weekly picture taken of the resident's skin condition, as set out in the resident's plan of care, which was not completed.

By not ensuring photographs were taken weekly, as ordered by the physician, there was an increased risk for wound deterioration.

Sources: Skin and wound assessments; Medication Administration Record; an interviews with two RPN's.

[741726]

iii. The licensee failed to ensure that the care set out in resident #002's plan of care was provided to the resident as specified in the plan, related to falls prevention and management.

Rationale and Summary
According to the resident's plan of care, the use of a device was to be implemented at all times when the resident was in their chair for the purpose of falls prevention. However, on one day, the Inspector

observed the resident seated in their chair without the device in place.

During an interview on the same day, a PSW confirmed that the device had not been implemented as specified in the resident's plan of care that day.

The licensee failed to ensure that the care set out in the resident's plan of care was provided to the resident as specified in the plan, when the device was not implemented for the purpose of falls prevention. As a result of this non-compliance, the resident was potentially at risk for a fall.

Sources: Observations of the resident; a review of the resident's health care records including progress notes, care plan, and point of care records; interviews with staff including a PSW.

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iv. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #007 as specified in the plan, related to the monitoring of the resident's condition following a medication incident.

Rationale and Summary
On review of the resident's plan of care including a Care Rx medication incident report, physician orders and the progress notes, it was found that a Nurse Practitioner (NP) had ordered vital signs and monitoring every hour for eight hours following a medication incident.

The resident's electronic and hard copy health records did not include any documentation to indicate that the resident was monitored or that vital signs were completed every hour for eight hours as ordered by the NP following the medication incident.

During separate interviews, a Registered Practical Nurse (RPN) and a Registered Nurse (RN) could not recall providing the care related to monitoring and completing vital signs on the resident every hour for eight hours following the medication incident, as ordered by the NP.

By not monitoring the resident as ordered by the NP, there was an increased risk that adverse reactions from receiving another resident's medications may go un-noticed by the registered staff.

Sources: Review of the Care Rx medication incident report, progress notes, weights and vital signs tab on point click care, physician orders and interview with an RPN and an RN.

[622]

v. The licensee failed to ensure that the care set out in resident #008's plan of care was provided to the resident as specified in the plan, related to falls prevention and management.

Rationale and Summary
It was alleged that the device in place as a falls prevention intervention for the resident was not being implemented as required.

The health care records were reviewed and found that the resident's plan of care included the use of a device for the purpose of falls prevention, to be used when the resident was in their chair. However, over the course of the inspection, the Inspector observed the resident to be in their chair, without the required device, on multiple occasions.

During interviews, a PSW indicated that the resident required a device when they were in bed - not while in their chair; whereas, another PSW indicated that the resident required a device while in their bed, and in their chair. At the same time, one of the PSW's recalled that the resident's device had been unavailable for a period of time, and therefore had not been implemented at all times.

The RAI Coordinator confirmed that, in accordance with the plan of care, the resident was required to have a device in place when in their chair. According to the RAI Coordinator, the use of a device for the resident when they were in their chair had been included in their plan of care for a year.

As a result of this non-compliance, the resident was potentially at risk for falls.

Sources: Resident health care records, including care plan, point of care records, and progress notes; and, interviews with staff including five PSW's, the RAI-Admissions Coordinator, and the RAI Coordinator; and observations of the resident.

[655]

This order must be complied with by November 15, 2023

REVIEW/APPEAL INFORMATION

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

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

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

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

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

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

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

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

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

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

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