Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 16, 2018	2017_580568_0028	027454-17	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF GREY
206 Toronto Street MARKDALE ON N0C 1H0

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

GREY GABLES HOME FOR THE AGED
206 TORONTO STREET SOUTH MARKDALE ON N0C 1H0

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

DOROTHY GINTHER (568), SHARON PERRY (155), TRACY RICHARDSON (680)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 13, 14, 15, 19, 20, 21, 2017 and January 2, 3, 4, 5, 9, 10, 2018.

Critical Incident log #024778-17 in relation to alleged staff to resident abuse; Follow-up to CO #001 related to neglect; CO #002 related to sufficient staffing; CO #003 related to resident's being assessed for pain, and CO #004 related to assessment of the effectiveness of medications were conducted in conjunction with the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care, Clinical Documentation & Information Coordinator, Maintenance Manager, Physician, Physiotherapist, Registered Dietitian, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Family Council and Residents' Council representatives, residents and their families.

The inspectors also toured the home, observed medication administration, medication storage, reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, posting of required information, medication incidents; observed the provision of resident care, resident-staff interactions, and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Sufficient Staffing

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

- **7 WN(s)**
- **4 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 134.	CO #004	2017_448155_0001	680
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_448155_0001	568
O.Reg 79/10 s. 31. (3)	CO #002	2017_448155_0001	568
O.Reg 79/10 s. 52. (2)	CO #003	2017_448155_0001	568

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

a) Review of a resident's clinical record showed that a Head to Toe Assessment was completed when the resident returned from hospital. The Head to Toe Assessment identified several areas of altered skin integrity.

During an interview with a Registered Practical Nurse (RPN) they said that when a new skin concern was identified they were to complete an initial skin assessment on Point Click Care (PCC). In the past these assessments were documented in a structured progress note, but they were now documented on the Skin / Wound Care assessment. Assessments were to be completed for all types of altered skin integrity including skin tears, pressure areas and bruises.

Review of the resident's clinical record identified a Skin / Wound Care Assessment, which was specific to one of the areas of altered skin integrity. There was no skin assessment in relation to the other areas of altered skin integrity identified in the Head to Toe Assessment.

The Acting Director of Care (DOC) said that when a resident returned from hospital it was the home's expectation that a skin assessment be conducted on all areas of altered skin integrity. After reviewing the identified resident's clinical record, the Acting DOC acknowledged that there were no skin assessments completed for several of the areas of altered skin integrity identified on the Head to Toe Assessment.

b) An identified resident's quarterly Minimum Data Set (MDS) assessment showed that the resident had an area of altered skin integrity. A weekly Skin / Wound Care assessment documented the location and status of the area of altered skin integrity. At a later date, a skin observation progress note documented by one of the registered staff also identified the area of altered skin integrity and probable cause. There was no documentation found in the identified resident's clinical record of an initial skin assessment related to the area.

In an interview with a PSW they said that the plan of care for the resident included several strategies to prevent the resident from developing altered skin integrity. The staff member shared that at present they were not aware of any areas of altered skin integrity but they recalled that there had been in the past.

The Acting DOC told inspector #568 that it was the home's expectation that all areas of altered skin integrity have an initial skin assessment and then weekly assessments until the skin concern resolved. The home transitioned to a new version of the skin assessment some time in September 2017. Upon review of the identified resident's record, the Acting DOC said they were unable to find an initial assessment of the resident's altered skin integrity.

The licensee failed to ensure that the identified residents who presented with altered skin integrity, received a skin assessment by a member of the registered staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) Review of an identified resident's clinical record showed that an initial Skin/Wound Care Assessment was completed on a specified date, in relation to one area of altered

skin integrity. A Head to Toe assessment completed at the same time identified that the resident had several other areas of altered skin integrity. There was no documentation in the clinical record of weekly wound assessments for any of the areas of altered skin integrity.

During an interview with the Acting DOC they said that weekly skin/wound assessments should be conducted for all areas of altered skin integrity until they resolved. After reviewing the identified resident's clinical record, the Acting DOC agreed that there were no reassessments of the resident's altered skin integrity as identified on the Head to Toe assessment.

b) A resident's quarterly Minimum Data Set (MDS) assessment identified that the resident had an area of altered skin integrity. A weekly Skin / Wound Care Assessment documented that the resident had an area of altered skin integrity and made note of it's location and status. There were no weekly skin assessments found from the time the altered skin integrity was first identified until five weeks later when it was noted that the area had worsened.

In an interview with the Acting DOC they said that it was the home's expectation that all areas of altered skin integrity have an initial skin assessment and then weekly assessments until the skin concern had resolved. Upon review of the identified resident's record, the Acting DOC said there were no weekly skin assessments completed during the five week period after the area of altered skin integrity was first identified.

The licensee failed to ensure that the identified residents' altered skin integrity were reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

During an interview with the resident they said they had needed assistance with toileting on a specified date. They used their call bell to get staff to come to assist them. While waiting, they tried to toilet themselves but were not successful. Because of the length of time it took staff to come they were incontinent which was very upsetting.

Review of the resident's plan of care showed that the Care Plan Checklist had not been completed. There was no indication as to the level of independence or staff interventions for toileting. The Kardex for the identified resident did not have any direction with respect to toileting or continence.

In an interview with a PSW they were able to tell the inspector what the identified resident's level of assistance was for toileting and what interventions were in place to maintain the resident's continence. The PSW reviewed the Kardex with Inspector #680 and acknowledged that there was nothing documented for toileting.

Review of the call bell log for the specified date, showed the call bell was activated for 21 minutes. Further review of the call bell log over a five day period, showed that the call bell had been activated 34 times. The call bell was activated for over 10 minutes on seven occasions.

In an interview with the Administrator they shared that an acceptable time frame to answer the call bell was five minutes. The Administrator stated that the staff should answer the call bell and return if unable to assist at that time. It was unacceptable for the identified resident to wait such a long time when they needed assistance with toileting. s. 51. (2) (c)]

2. During an interview with a resident they told inspector #568 that there were times when they rang their call bell over and over and no one came for a long time. In some of these cases the resident said that they ended up incontinent which was very upsetting to them. The resident could not recall specific dates or times but said that this was an ongoing problem and not an isolated incident.

Review of the resident's plan of care identified that the resident required staff to provide assistance for toileting. According to the most recent Minimum Data Set (MDS) assessment, the resident was identified as having some degree of continence.

In an interview with a PSW they shared that the resident required staff to assist with toileting needs. The resident was aware of when they needed to use the washroom most of the time and were continent some of the time.

Inspector #680 spoke with a PSW who said that sometimes residents have to wait to be toileted and they may be incontinent because they are short of staff. The PSW said that this has happened to the identified resident a couple of times in the last few weeks. They complained to staff that they needed to go to the washroom and by the time they had the staff available to toilet them they had been incontinent.

When the call bell log for the identified resident was reviewed for a twelve day period, it was noted that there were 28 calls where the resident waited more than 10 minutes for their call bell to be answered. The response times for these 28 calls varied between 10 minutes and 12 seconds and 46 minutes and 56 seconds. Of those 28 calls there were only three occasions when the home was short of staff based on their staffing schedules.

In an interview with the home's Administrator they said that residents waiting more than five minutes when they have called for assistance using the call bell would be a concern. With respect to the identified resident it was not acceptable that a resident that needed assistance for toileting to maintain their continence was kept waiting for such an extended period of time.

The licensee failed to ensure that the identified residents, who were unable to toilet independently some or all of the time, received the assistance from staff to manage and maintain continence. [s. 51. (2) (c)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care included an order by the physician or the registered nurse in the extended class.

During observations on a specified date, a resident was found resting in bed with a physical device in place.

In interviews with two PSW's they said that when the resident was in bed they were instructed to apply a physical device. When asked what the reason for the device was, the PSW's said that it was for resident safety; to prevent the resident from getting out of bed.

In a review of the resident's clinical record it was noted under the Kardex that the resident had a restraint. The restraint was identified as a specific physical device. Instructions to staff were to check the restraint every hour for safety/comfort, release, reposition and reapply every two hours. The Restraint / Personal Assistance Services Device (PASD) assessment stated that the resident had the specific device in place when in bed. The device was identified as a restraint. The plan of care did not include an order by the physician or registered nurse in the extended class for the device as a restraint.

During an interview with the Clinical Documentation and Information Coordinator (CDI), they said that the resident's substitute decision maker (SDM) had requested that the physical device be applied when the resident was in bed. The CDI stated that the device was a restraint and acknowledged that there was no physician's order in the plan of care for the identified restraint.

The licensee failed to ensure the the restraint plan of care included an order by the physician or nurse in the extended class. [s. 31. (2) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the restraint plan of care included an order by the physician or the registered nurse in the extended class, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) was reviewed in relation to an allegation of abuse from a staff member towards a resident.

The report showed that a resident reported to a RPN that a PSW had given rough care.

The identified resident shared that a PSW completed care without the appropriate level of assistance and staff. As a result they had been rough while providing care to the resident.

During an interview with the PSW, they recalled the incident identified in the CIS report. They said that they had pushed the call bell to get further assistance from another staff, but in the interim they initiated care on their own. They acknowledged that they had not provided care to the resident with the appropriate level of staff assistance.

The Administrator said the home had investigated the incident and found that the staff member had not provided care as outlined in the resident's plan of care and had not used safe repositioning techniques when assisting residents.

The licensee failed to ensure that staff used safe positioning techniques when assisting resident #041. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were monitored during meals, including residents eating in locations other than the dining area.

During an observation at breakfast a resident was sitting at a table in the dining room eating. There were four other residents in the dining room, some of which had drinks in front of them. There were no staff present in the area.

Review of the home's policy titled "Meal Service", last revised May 2015, it stated "Residents are never left unattended in the dining rooms. It is recommended that a nursing staff member be present at all times during the meal service".

The identified resident's plan of care stated that the resident was on a specified diet texture. Progress notes documented that the resident required a certain level of assistance and may need encouragement.

The identified resident shared with Inspector #680 that they had often been left in the dining room alone.

The substitute decision maker (SDM) for the resident said that when they visit, they have found the resident sitting in the dining room alone and they take them back to their room. The SDM stated that the resident had some difficulty eating.

The Acting Director of Care observed the dining room area with the Inspector and acknowledged that there were residents in the dining room and no staff were present at that time.

The licensee has failed to ensure that residents were monitored during meals, including residents eating in locations other than dining area. [s. 73. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents were monitored during meals, including residents eating in locations other than the dining area, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

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

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

a). A medication incident report stated that a resident was administered a medication at supper. The physician's order was that the resident receive the prescribed medication two times a day at 0800 hours and at 2000 hours. On a specified date the resident was administered the medication at 0800 hours, at supper (1700 hours) and at 2000 hours. The medication incident report and the resident's progress notes identified that the attending physician/prescriber of the drug was notified, however, there was no documentation to support that the Medical Director was notified.

During an interview with Acting Director of Care, they shared that they could not substantiate whether the Medical Director was notified of this medication incident as it was not documented on the medication incident form. The Acting Director of Care shared that when medication incidents are reported to the Medical Director it was to be documented on the medication incident report form and this was not done.

b) A medication incident report stated that a resident was not given a prescribed medication at 1400 hours and that the nurse could not locate the 1700 hour strip medication package. Review of the resident's Medication Administration Record (MAR) for the specified date showed that the resident was to get two prescribed medications at 1700 hours. These medications were not given at 1700 hours as the nurse documented that they could not find the 1700 hour strip package and was unable to determine if the medications had been given earlier in the day and did not want to double dose the resident. The medication incident report and the resident's progress notes did not identify if the medication incident was reported to the resident, the resident's SDM, if any, the Medical Director, the prescriber of the drug, the resident's attending physician and the pharmacy service provider.

During an interview with the Acting Director of Care, they could not substantiate whether the resident, the resident's SDM, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician and the pharmacy service provider would have been notified of this medication incident as it was not documented on the medication incident form. The Acting Director of Care shared that when medication incidents are reported those notified of the incident were to be documented on the medication incident report form and this was not done.

c) A medication incident stated that a resident was administered the wrong dose of a prescribed medication at 1200 hours. The medication incident report and resident's progress notes did not identify if the medication incident was reported to the resident and the resident's SDM, if any. During an interview with the Acting Director of Care, they

could not substantiate if the resident and the resident's SDM were notified of this medication incident as it was not documented on the medication incident form. The Acting Director of Care shared that when medication incidents are reported to the appropriate people it was to be documented on the medication incident report form.

During an interview with the Administrator they said that it was the home's expectation that when there was a medication incident involving a resident the appropriate people would be notified by the registered staff and/or the Director of Care and it would be documented.

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

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

a) A medication incident report stated that a resident was not given a prescribed medication at 1400 hours and that the nurse could not locate the 1700 hour strip medication package. Review of the resident's Medication Administration Record for the specified date showed that the resident was to be given two prescribed medications at 1700 hours. These medications were not given at 1700 hours as the nurse documented that they could not find the 1700 hour strip package and was unable to determine if the medications had been given earlier in the day and did not want to double dose the resident.

A review of this medication incident showed that the analysis of the incident and corrective action plan were blank and that this form was not signed by the Director of Care.

During a review of this medication incident and a review of the resident's Medication Administration Record with the Acting Director of Care it was established who the registered staff member was that made the error.

b) A medication incident report stated that a resident was administered a medication at supper and again at bedtime. The physician's order was that the resident was to get the medication two times a day at 0800 hours and at 2000 hours.

A review of this medication incident report showed that the analysis of the incident and the corrective action plan was completed by a RPN. During an interview with the RPN they shared that they filled out the medication incident report when they realized they had made the error. They shared that the Director of Care did not have any discussion with them about the error. Review of the medication incident report showed that the Director of Care did not sign or date this report.

c) A medication incident stated that a resident was administered the wrong dose of a prescribed medication on a specified date at 1200 hours. A review of this medication incident showed that the corrective action plan was blank and that this form was not signed by the Director of Care.

During a review of this medication incident and a review of the resident's MAR with the Acting Director of Care it was established that the registered staff member that had made the error was a RPN.

During an interview with the RPN and review of the resident's MAR for the specified date, the RPN shared that according to the signatures on the MAR they had made the error. The RPN shared that this was the first that they were notified of this incident and that they had no prior knowledge that they had made this mistake.

During an interview with the Administrator they shared that it was the expectation that when there was a medication incident that the Director of Care would follow up with the appropriate staff; review, analyze and take corrective action as necessary. They shared the medication incident form should be completed in full and signed by the Director of Care.

The licensee failed to ensure that:
(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary and; (c) a written record was kept of everything required under clauses (a) and (b). [s. 135. (2)]

3. The licensee failed to ensure that: (a) a quarterly review was undertaken of all

medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions,
(b) any changes and improvements identified in the review were implemented, and
(c) a written record was kept of everything provided for in clause (a) and (b).

During this Resident Quality Inspection the Classic Care Pharmacy 2017 Quantitative Incident and Adverse Event Analysis was reviewed along with the Medication Incident Reports for the specified time period. The Classic Care Pharmacy analysis showed that there were no pharmacy incidents and four non-pharmacy incidents. The Medication Incident Reports showed that there were no pharmacy incidents and five non-pharmacy incidents.

Review of the Medication Incident Reports with the Acting Director of Care was done and they shared that there was no documentation to support that the pharmacy was faxed the medication incident report of a specified date.

Review of the Medication Incident Reports for two specified dates for two different residents it was noted that there was no follow up done with the staff involved in the incidents. During interviews with the RPN's involved they shared that they were not aware of the incidents.

The three medication incidents reviewed were not signed by the Director of Care and the Acting Director of Care shared that they should have been signed. The Acting Director of Care shared that medication incidents were discussed at the Professional Advisory Committee meeting but only as far as whether they were pharmacy or non-pharmacy errors.

Review of the Professional Advisory Committee meeting minutes, under the pharmacy section it stated medication errors discussed. Pharmacy was working on a medication error audit to reduce medication errors in the home. The home would participate in a survey and a Registered Nurse from Classic Care would observe a medication pass. Under the action section of the meeting minutes it stated they were tracking medication errors and prevention.

During an interview with the Administrator they shared that a proper quarterly review could not be done if the pharmacy was not aware of all of the medication incidents nor if the Director of Care did not follow up the incidents with the registered staff.

The licensee failed to ensure that: (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; (b) any changes and improvements identified in the review are implemented and; (c) a written record is kept of everything provided for in clause (a) and (b). [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that
(1) Every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy provider;

(2) (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; (b) corrective action taken as necessary; (c) and a written record is kept of everything required in clauses (a) and (b);

(3) (a) A quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; (b) any changes and improvements identified in the review are implemented; (c) and a written record is kept of everything provided for in clause (a) and (b)., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a 24-hour admission care plan was developed for an identified resident.

During an interview with the resident they shared that at night specific interventions were in place with respect to toileting. The resident said that they needed assistance with toileting on a specific date. They had called using their call bell and when no one came they tried to to toilet themselves but were not successful. Unfortunately no staff came for quite a while and they were incontinent.

Review of the Kardex for the resident showed that there was no documentation for several of the activities of daily living in terms of what level of assistance and interventions were required. The Kardex did not document toileting routines for the resident.

Review of the care plan checklist for the resident showed that the following had not been completed:
Bed mobility- there was nothing marked on this section;
Bladder function - there was no mention of times or routine on the form. Level of continence was not completed on the form.

In an interview with a PSW they shared that they noticed the Kardex for the identified resident only had documentation under the Eating/Nutrition section and that they had brought this to the attention of the registered staff. A PSW told Inspector #680 that the identified resident had a Kardex on point of care (POC) and that the Kardex provided direction for staff regarding the resident's care. When reviewing the Kardex for the identified resident the PSW said there was nothing documented for toileting or continence.

A Registered Nurse (RN) shared that when they had a new admission a progress note

was generated and the care plan was initiated immediately. The RN said that each shift was responsible to update the plan of care and they acknowledged that this had not been done for the identified resident.

The Acting Director of Care (DOC) shared that the 24 hour care plans should be available for PSWs on their Kardex. They acknowledged that the 24 hour plan of care for the identified resident was not complete and therefore did not provide direction to staff in relation to the resident's care needs.

The licensee has failed to ensure that a 24-hour admission care plan was developed for the identified resident. [s. 24. (1)]

Issued on this 1st day of March, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DOROTHY GINTHER (568), SHARON PERRY (155), TRACY RICHARDSON (680)
Inspection No. / No de l'inspection :	2017_580568_0028
Log No. / No de registre :	027454-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 16, 2018
Licensee / Titulaire de permis :	CORPORATION OF THE COUNTY OF GREY 206 Toronto Street, MARKDALE, ON, N0C-1H0
LTC Home / Foyer de SLD :	GREY GABLES HOME FOR THE AGED 206 TORONTO STREET SOUTH, MARKDALE, ON, N0C-1H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jennifer Cornell

To CORPORATION OF THE COUNTY OF GREY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that the identified residents' and any other resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or bruises,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment;
(iv) is reassessed at least weekly by a member of the registered nursing staff.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

a) Review of a resident's clinical record showed that a Head to Toe Assessment was completed when the resident returned from hospital. The Head to Toe Assessment identified several areas of altered skin integrity.

During an interview with Registered Practical Nurse (RPN) they said that when a new skin concern was identified they were to complete an initial skin assessment on point click care (PCC). In the past these assessments were documented in a structured progress note, but they were now documented on the Skin / Wound Care assessment. Assessments were to be completed for all types of altered skin integrity including skin tears, pressure areas and bruises.

Review of the resident's clinical record identified a Skin / Wound Care Assessment which was specific to one of the areas of altered skin integrity. There was no skin assessment in relation to the other areas of altered skin integrity identified in the Head to Toe Assessment.

The Acting Director of Care (DOC) said that when a resident returned from hospital it was the home's expectation that a skin assessment be conducted on all areas of altered skin integrity including bruises. After reviewing the identified resident's clinical record, the Acting DOC acknowledged that there were no skin assessments completed for several areas of altered skin integrity identified on the Head to Toe Assessment.

b) An identified resident's quarterly Minimum Data Set (MDS) assessment showed that the resident had an area of altered skin integrity. A weekly Skin /

Wound Care assessment documented the location and status of the area of altered skin integrity. At a later date, a skin observation progress note documented by one of the registered staff also identified the area of altered skin integrity and probable cause. There was no documentation found in the identified resident's clinical record of an initial skin assessment related to the area.

In an interview with a PSW they said that the plan of care for the resident included several strategies to prevent the resident from developing altered skin integrity. The staff member shared that at present they were not aware of any areas of altered skin integrity but they recalled that there had been in the past.

The Acting DOC told inspector #568 that it was the home's expectation that all areas of altered skin integrity have an initial assessment and then weekly assessments until the skin concern resolved. The home transitioned to a new version of the skin assessment some time in September 2017. Upon review of the identified resident's record, the Acting DOC said they were unable to find an initial assessment of the resident's altered skin integrity.

The licensee failed to ensure that resident #022 and resident #001 who presented with altered skin integrity, received a skin assessment by a member of the registered staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.
(568)

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) Review of resident #022's clinical record showed that an initial Skin/Wound Care Assessment was completed on a specified date, in relation to one area of altered skin integrity. A Head to Toe assessment completed at the same time identified that the resident had several other areas of altered skin integrity. There was no documentation in the clinical record of weekly wound assessments for any of the areas of altered skin integrity.

During an interview with the Acting DOC they said that weekly skin/wound assessments should be conducted for all areas of altered skin integrity until they

had resolved. After reviewing the identified resident's clinical record, the Acting DOC agreed that there were no reassessments of the resident's altered skin integrity as identified on the Head to Toe assessment.

b) A resident's quarterly Minimum Data Set (MDS) assessment identified that the resident had an area of altered skin integrity. A weekly Skin / Wound Care Assessment documented that the resident had an area of altered skin integrity and made note of it's location and status. There were no weekly skin assessments found from the time the altered skin integrity was first identified until five weeks later when it was noted that the area had worsened.

In an interview with the Acting DOC they said that it was the home's expectation that all areas of altered skin integrity have an initial skin assessment and then weekly assessments until the skin concern resolved. Upon review of the identified resident's record, the Acting DOC said there were no weekly skin assessments completed during the five week period after the area of altered skin integrity was first identified.

The licensee failed to ensure that the identified residents' altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

The severity of this noncompliance was determined to be a level two with potential for actual harm; and the scope was identified as being a pattern. The compliance history was a level 3 with one or more related noncompliance in the last three years. A voluntary plan of correction (VPC) was issued January 10, 2017, in inspection #2017_448155_0001. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall ensure that the identified residents' and any other resident that is continent or has been assessed as being potentially continent or continent some of the time, receives the assistance and support from staff to manage and maintain their continence.

Grounds / Motifs :

1. The licensee failed to ensure that each resident who was unable to toilet independently some or all of the time received the assistance from staff to manage and maintain continence.

During an interview with a resident they told inspector #568 that there were times when they rang their call bell over and over and no one came for a long time. In some of these cases the resident said that they ended up being incontinent before the staff arrived which was very upsetting. The resident could not recall specific dates or times but said that this was an ongoing problem and not an isolated incident.

Review of the resident's plan of care identified that the resident required staff to provide assistance for toileting. According to the most recent Minimum Data Set (MDS) assessment, the resident was identified as having some degree of continence.

In an interview with a PSW they shared that the resident required staff to assist with toileting needs. The resident was aware of when they needed to use the washroom most of the time and were continent some of the time.

Inspector #680 spoke with a PSW who said that sometimes residents have to wait to be toileted and they may be incontinent because they are short of staff. The PSW said that this has happened to the identified resident a couple of times in the last few weeks. They complained to staff that they needed to go to the washroom and by the time they had the staff available to toilet them they had been incontinent.

When the call bell log for the identified resident was reviewed for a twelve day period, it was noted that there were 28 calls where the resident waited more than 10 minutes for their call bell to be answered. The response times for these 28 calls varied between 10 minutes and 12 seconds and 46 minutes and 56 seconds. Of those 28 calls there were only three occasions when the home was short of staff based on their staffing schedules.

In an interview with the home's Administrator they said that residents waiting more than five minutes when they have called for assistance using the call bell would be a concern. With respect to the identified resident it was not acceptable that a resident that needed assistance for toileting to maintain their continence was kept waiting for such an extended period of time. (568)

2. During an interview with the resident they said they had needed assistance with toileting on a specified date. They used their call bell to get staff to come to assist them. While waiting, they tried to toilet themselves but they were not able to. Because of the length of time it took staff to come they were incontinent which was very upsetting.

Review of the resident's plan of care showed that the Care Plan Checklist had not been completed. There was no indication as to the level of independence of the resident, nor did it provide interventions related to toileting. The Kardex for the identified resident did not have anything documented for toileting or continence.

In an interview with a PSW they were able to tell the Inspector what the toileting plan was for the identified resident and what level of assistance was required. The PSW reviewed the Kardex with Inspector #680 and acknowledged that there was nothing documented for toileting.

Review of the call bell log for the specified date, showed the call bell was activated for 21 minutes. Further review of the call bell log over a five day period, showed that the call bell had been activated 34 times. The call bell was activated for over 10 minutes on seven occasions.

In an interview with the Administrator they shared that an acceptable time frame to answer the call bell was five minutes. The Administrator stated that the staff should answer the call bell and return if unable to assist at that time. It was unacceptable for the identified resident to wait such a long time when they needed assistance with toileting.

The licensee failed to ensure that resident #045 and #023, who were unable to toilet independently some or all of the time, received the assistance from staff to manage and maintain continence.

The severity of this noncompliance was determined to be a level three as there was actual harm to the resident; and the scope of this issue was identified as isolated. The home does not have a history of noncompliance in this subsection of the Long Term Care Homes Act and Regulations. (680)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 16th day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Dorothy Ginther

Service Area Office / Bureau régional de services : London Service Area Office