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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 26, 2016	2016_293554_0020	013496-16	Resident Quality Inspection

Licensee/Titulaire de permis

HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION
7199 Gelert Road Box 115 HALIBURTON ON K0M 1S0

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

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

KELLY BURNS (554), CATHI KERR (641), SAMI JAROUR (570), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 19-23 and September 26-30, 2016.

Resident Quality Inspection (RQI) Intake #013496-16. There were eight additional intakes assigned to the RQI and such were inspected concurrently with this inspection; the intakes assigned included, #014394-16, 014684-16, 015734-16, 015737-16, 015738-16, 025215-16, 025670-16 025968-16.

Summary of Intakes:
1) 014394-16 – Critical Incident Report, specific to resident to resident abuse;
2) 014684-16 – Critical Incident Report, specific to an incident that causes an injury to a resident for which the resident is taken to hospital and the injury has resulted in a significant change in the resident's health condition;
3) 015734-16 – Follow Up to inspection report #2016_360111_0008, specific to LTCHA, 2007, s. 6 (7); compliance order #001, with a compliance due date of August 31, 2016;
4) 015737-16 – Follow Up to inspection report #2016_360111_0008, specific to LTCHA, 2007, s. 20 (1); compliance order #002, with a compliance due date of August 31, 2016;
5) 015738-16 – Follow Up to inspection report #2016_360111_0008, specific to LTCHA, 2007, s. 86 (3); compliance order #003, with a compliance due date of August 31, 2016;
6) 025215-16 – Critical Incident Report, specific to an unexpected death of a resident;
7) 025670-16 – Critical Incident Report, specific to an incident that causes an injury to a resident for which the resident is taken to hospital and the injury has resulted in a significant change in the resident's health condition;
8) 025968-16 – Critical Incident Report, specific to a witnessed incident of resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with Acting Administrator, Director of Care, Associate Director of Care, Dietary Manager, Director of Environmental Services and Projects, RAI-C, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker (PSW), Housekeeping Aide, Maintenance Worker, Physio-Therapy Assistant (PTA), Physiotherapist (PT), Family Council Co-Chair, Resident Council President, Residents and Families.

Also during the course of this inspection, the inspectors, toured the home, observed meal service, medication administration, staff to resident interactions, and resident to resident interactions, reviewed clinical health records, minutes of both the Family and Resident Councils, maintenance request logs, re-training records (specific to falls prevention, restraints, reporting and investigation of abuse), reviewed corrective action plans specific to follow up identified compliance orders, reviewed home policies, specifically, Mandatory and Critical Incident Reporting, Restraint Implementation Protocols, Responsive Behaviours, Hydration and Nutrition Monitoring, Zero Tolerance of Abuse and Neglect, Hand Hygiene,

Cleaning and Disinfection of Non-Critical Medical Equipment and Devices, Cleaning and Disinfection of Nail Clippers, Pneumococcal Vaccine, Tetanus Diptheria Vaccine, Tetanus Diptheria Pertussis Vaccine, Influenza Vaccine, Tuberculosis Screening of Residents, Documentation and Work Flow, Shower and Spa Specifications – Housekeeping, Cleaning Bathroom, Shower and Soaker Tubs, Housekeeping Work Routines and Cleaning Frequency Schedules, Falls Prevention and Management, Pain and Symptom Assessment Protocol, Medications, Security and Accountability, Administering Medications, Documentation of Medications, Administering Oral Medications, Medication Storage, Resident Self Administration, Administering Various Forms of Medications, Narcotics and Controlled Drugs, and Statement of Mission for Pharmacy Services.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #002	2016_360111_0008	570
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2016_360111_0008	623
LTCHA, 2007 S.O. 2007, c.8 s. 86. (3)	CO #003	2016_360111_0008	554

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care, for each resident sets out clear directions to staff and others who provide direct care to the resident, specifically use of restraints for resident #039.

Related to Resident #039:

Resident #039 has a history which includes cognitive impairment. Resident is known to be at risk for falls.

Resident #039 was observed, during the dates of this inspection, sitting in a mobility aid (chair) with a restraint in place. Resident #039 was unable to release restraint upon direction of the inspector.

A review of the health care record for resident #039 contained the following information specific to the care of this resident.

The written plan of care indicated:

Mobility:

- Resident #039 walks independently with a mobility aid. Staff to reinforce the use of the mobility aid; resident uses the mobility aid when walking. Resident frequently forgets to use the mobility aid.
- Resident #039 is dependent in another identified mobility aid (chair); the mobility aid has a restraint. Restraint used in the mobility aid (chair) at times when resident becomes tired/fatigued; resident is at increased risk of falling.
- Walk resident to and from dining room;
- Staff are to engage one assistive device when in bed and keep resident's identified mobility aid within reach on the open side of the bed.

Falls Risk:
- Restraint; two assistive devices up when in bed. Check on resident #039 at least hourly; reposition and document in restraint record every hour.
- Frequent and daily reminders to use an identified mobility aid, as resident #039 will leave the mobility aid in various locations.

Restraint:
- Apply restraint when resident is in the identified mobility aid, remove and reposition every two hours and any other time when necessary.
- Restraint is not to be used routinely, it is only to be used when resident #039 is at increased risk of falling; only used if wandering/walking, or when resident seems tired or fatigued.

Physician's Orders:
- on an identified date – discontinue use of two assistive devices for resident #039
- on an identified date – (as per "three month medication review", for the identified three month period) – Restraints to be used: two assistive devices when in bed for safety; restraint when in the identified mobility aid for safety.

Point of Care (electronic resident care flow sheet record):
- Restraint Use – PRN restraint in mobility aid if needed for increased risk of falls due to fatigue/unsteadiness with frequent wandering/walking. Please document every hour if in use. (PRN, as needed)

Registered Nurse (RN) #109, who is the charge nurse, indicated being "unsure how often resident #039 uses the identified mobility aid and restraint". RN #109 indicated he/she would need to check the resident's plan of care. RN #109 and inspector together checked the plan of care for resident #039. RN #109 indicated that according to the plan

of care "resident #039 only uses the identified mobility aid with restraint when tired or fatigued".

Personal Support Workers #103 and #115 both indicated "resident #039 no longer walks and uses an identified mobility aid with a restraint at all times when he/she is not in bed". Personal Support Workers (#103 and #115) indicated the "resident cannot unfasten the restraint". Both indicated "resident #039 has used the identified mobility aid and restraint since an identified date, following a fall."

Personal Support Workers #103 and #115, both indicated "resident no longer uses two assistive devices, only uses one assistive device when in bed". (Note: resident was not observed in bed during this inspection)

Registered Nurse #101, and #104, along with PSW #103 and the RAI-C all indicated that the plan of care for resident #039 does not provide clear direction, regarding, resident's walking ability, use of an identified mobility aid and or specific restraint use". All indicated "resident #039 no longer walks and is seated within the mobility aid with restraint in place on a daily basis, whenever resident is not in bed".

The licensee has failed to ensure that the written plan of care provided clear directions to direct care staff and others specific to the care requirements of resident #039. [s. 6. (1) (c)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other related to falls.

Resident #039, has a history which includes cognitive impairment.

Review of the falls risk assessments by the inspector, for two specific time periods, identifies that resident #039 is at risk for falls.

Review of the current care plan, identifies resident #039 as a risk for falls characterized by history of falls/ injury. Interventions to mitigate falls include; Encourage resident to use handrails or assistive devices properly. Engage 1 assistive device when in bed (on window side) and keep mobility aid within reach on open side of the bed. Family has provided non slip socks as he/she does not like to wear shoes or slippers; cut the hems off of his/her pant legs to decrease risk of tripping/falls. Frequent and daily reminders for resident to use mobility aid when ambulating as resident will leave mobility aid in various

places and ambulate without it. Maintain bed in lowest position at all times.

Observations by the inspector in resident #039's room indicated that the following interventions are in place; a leaf logo (identifying the falling leaf program) is posted on the wardrobe door. A falls mat is beside the bed on the window side. There is a notice posted on wall at head of bed stating "no side rails" and the bed is in lowest position.

There is a notice posted on the wall in resident #039's room stating:
- "Falls Prevention Measures" identifies the following; Put mattress next to bed, proper foot wear, keep bed alarm on, high pyjamas/high pants. Precautions to follow: Keep bed alarm on for the residents who are at risk of getting rolled over the bed rail. Make sure residents are wearing proper foot wear. Make sure residents are wearing high pyjamas.

Review of the progress notes in Point Click Care for a four month period identifies, the following:

- On a specified date and time, resident #039 was placed into an identified mobility aid (chair) due to feet dangling in the air when in another mobility aid, to provide more support to his/her legs.
- On an identified date and specific time – RN# 104 spoke with restorative care and questioned if there was another mobility aide available with tilt and restraint to trial for resident #039. A suitable mobility aid was located and trialed for a few hours resulting in resident making several attempts to undo the restraint and get out of the identified mobility aid. Resident was returned to his/her perscribed mobility aid.

During an interview, PSW#115 confirmed that he/she provides care to resident #039. PSW #115 stated that currently resident #039 is in an identified mobility aid (chair) at all times with a restraint in place, and this is documented in POC. PSW indicated that resident #039 has been using the identified mobility aid for about 6 weeks and is no longer up walking independently with his/her mobility aid. PSW indicated that at least once per shift they will stand resident #039 and attempt to walk him/her but he/she is becoming weaker. PSW identified the following falls prevention measures for resident #039; mat at the bed side, no bed rails, bed in lowest position, check q1hour when in bed, try to keep him/her non-skid socks on but resident is usually not cooperative and prefers bare feet. PSW #115 confirmed that resident does not have a bed alarm. PSW indicated that it was trialed but it bothered the resident in the room next door so they stopped using it. PSW believes that since putting resident #039 into the newest mobility aid (chair) with the restraint there have been less falls. PSW indicated that there was a

falls prevention committee in place but only for a short time, he/she does not believe that it is meeting anymore. PSW #115 indicated that he/she was part of the initial team in the spring of 2016, but has not attended a meeting for a few months.

During an interview, RN #104 indicated that he/she is aware of a falls prevention program in the home but he/she is not part of the team. RN indicated that he/she believes the falls prevention program is overseen by the DOC and ADOC. The team includes physiotherapy and programs as well as PSW's. The Registered Nurses on the floor the day the meeting is taking place are supposed to try to attend the meeting but time rarely allows for this. RN #104 confirms that the registered nurses and the RAI Coordinator are responsible to update the care plan with any changes in resident condition but that they have not updated resident #039's plan of care to reflect his/her current needs. RN confirmed that when a resident falls it is the expectation of the home for the registered nursing staff to assess the resident, document in the progress notes in point click care (PCC) under falls, complete a risk management assessment in PCC that will generate a referral to physiotherapy to assess the resident post fall. If the fall is unwitnessed or if the resident hits their head, then a head injury routine is initiated.

During an interview, PT #117 confirmed that Resident #039 is in the falls prevention program. PT #117 stated that he/she posted the "Fall Prevention Measures" poster in resident #039's room and that it is a "general poster" and not specific to the resident. These are options or suggestions for staff to try, but are not specific to any particular resident. PT #117 confirms that resident #039 does not use the bed alarm. The staff only used this for a short time and it was not successful. Resident #039, is in an identified mobility aid (chair) full-time because he/she was taking the restraint off or sliding while in another mobility aid. PT#117 confirmed that resident #039 is now not able to undo the identified restraint, as it is a different restraint for this resident. Resident #039 has had no more falls since he/she was put into the identified mobility aid (chair). PT#117 confirms that he/she updates the physiotherapy section of the care plan only. PT does this quarterly as per the RAI/MDS schedule and with any changes in status as well; the PT completes the transfer assessment for the residents. PT#117 confirms that he/she does not update the transfer logo in the room, the falling leaf, or the parts of the care plan related to transfers; this is to be done by nursing.

During an interview, RAI Coordinator #100 indicated that there is a falls prevention program in place but that he/she is not involved in this program. RAI Coordinator believed that this was overseen by two PSW's #115 and #119. RAI Coordinator confirmed that he/she updates care plans in PCC but only on a quarterly scheduled

basis. He/she indicated that when a resident has a significant change, he/she would not likely have the time to make the changes in the care plan. RAI coordinator confirmed that the care plan in PCC should have the most up to date information related to the residents current care needs, but that they might not always be up to date. After reviewing the PCC care plan for resident #039, RAI Coordinator confirms that the care plan fails to identify that resident #039 is using an identified mobility aid (chair) at all times with a restraint and that he/she is no longer ambulating independently with a mobility aid. RAI Coordinator confirms that the resident status has changed. RAI Coordinator confirmed that the falls prevention measures posted on the wall in the resident’s room are supposed to be reflective of the care staff are to provide. RAI Coordinator confirmed that there is no bed alarm in resident #039's room. He/she stated that he/she believed that there was only one bed alarm in the building and that they don't usually work so the staff don't use them. RAI Coordinator confirmed that the bed alarm is not identified in the plan of care in PCC but is posted in the room for the PSW's to use.

During an interview, the DOC confirmed that the homes expectation for when a resident falls, is that the registered nurse will complete an assessment of the resident, document the incident in detail in a progress note and complete a falls incident report under Risk Management in PCC. The DOC indicated that she reviews the risk management in point click care on a weekly basis to read and sign off the incidents that have been documented in the home. The DOC confirms that the RAI Coordinator is responsible for monitoring to ensuring that care plans are kept current and are reflective of the care needs for the residents; this has not been happening.

Therefore the licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other related to falls for resident #039. (623) [s. 6. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring the written plan of care for residents sets out clear directions to direct care staff and others who provide direct care to the resident, specific restraints; and to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, specific to falls risk and or prevention, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specifically medication management systems.

Under O. Reg. 79/10, s. 114 (2), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home's policies specific to Medication Management Systems are as follows:

- Medications Security and Accountability (VI-J-10.24) directs that registered nursing staff will follow the standards of practice for medication administration as documented by the College of Nurses of Ontario.

- Administering Medications (#3-012) directs that all personnel must follow established legislation and standards when administering medications. The policy further directs that all drugs are to be administered in accordance with the directions for use.

- Documentation of Medications (#3-014) directs that all medications must be recorded accurately on the Medication Administration Record when they are administered. The policy further states all entries of medication administered on the Medication Administration Record (or electronic eMAR) must be made after the administration to the resident.

- Administering of Oral Medications (#3-017) directs that prior to the administration of medications, that registered nursing staff will identify the resident by name band, photo or other means and that two ways of identifying the resident should be used; explain the procedure to the resident before administering the medication; the label (of the drug or medication strip) and the Medication Administration Record must be read three times before administering medication to the resident; and when administering oral medication, the nurse is to remain with the resident until he/she has taken the medication. The policy states that medication is NEVER to be left with the resident, unless the policy "Leaving Medications with the Resident" is followed.

- Administering of Eye Drops (#3-018) directs that registered nursing staff will wash hands with soap and water immediately before and immediately after the administration of eye drops.

- Resident Self Administration of Medications (#4-007) directs that a doctor's order must be obtained for registered nursing staff to leave medications with a resident. The said resident must be deemed capable.

The Director of Care and the Associate Director of Care both indicated "all registered nursing staff have been provided education specific to the medication management policies and or procedures". The Director of Care indicated "it is an expectation that registered nursing staff follow standards as described by their regulatory bodies (College of Nurses of Ontario)".

On an identified date, during this inspection, Registered Nurse (RN) #109 was observed not abiding by the home's policies, specific to medication management systems, as observed by the following:

- RN #109 was observed carrying a tray of medication cups; contained within the medication cups were drugs (pills, capsules and liquid). RN #109 had pre-poured medications for approximately eight to ten residents. RN #109 was not observed performing the "Rights of Drug Administration" during this observation nor was he/she observed to have medication administration records or physicians orders with him/her.
- RN #109 was not observed signing for medications, which had been pre-poured and or left at dining room tables; the home's policy states that medication administration must be accurately recorded and the eMAR must be signed immediately after the said medication administration.
- RN #109 was observed leaving the tray of pre-poured medications unattended on the nursing station (upper resident home area), as RN #109 administered medications from the tray to residents, sitting in the lounge. RN #109 was observed on two occasions with his/her back to the tray of medications. During this same observation, residents were observed walking past the tray, which contained medication (drugs), which were left unattended on the counter of the nursing station. RN #109 did not ensure that medications (drugs) were safety stored or in a locked area when he/she wasn't in attendance.
- RN #109 was observed leaving medications, for at least five residents on dining room tables. Residents were not observed sitting at the tables where medications were left unattended by RN #109; RN #109 did not identify the resident or residents who were to receive medications, nor did RN #109 explain medication procedures prior to administering medications to the identified residents, as stated in home specific policies.
- RN #109 was observed administering eye drops to an identified resident sitting at table #3 in the dining room; RN was not observed performing hand hygiene before and or after the said administration, as per home specific policies.

The Director of Care indicated that "RN #109 has presented performance issues in the past, specific to medication management systems and safety". DOC provided the inspector with medication incidents specific to medication errors found on a indicated date.

The Director of Care indicated that RN #109 has been provided counselling, as recently as July 2016, specific to medication management and safe medication administration

practices.

Registered Nurse #109 indicated being aware of the home's policies and procedures specific to medication management. RN #109 indicated that "it is his/her practice to pre-pour medications".

The Director of Care indicated that the actions observed by RN #109 on the identified date, during the specified medication administration pass, do not meet the medication administration polices or procedures of the organization.

Registered Nurse #109 was placed on a leave pending investigation for not following safe medication practices. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specifically as it relates to medication management systems, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

The following was observed during dates of this inspection:

- Ceramic Wall Tiles – wall tiles in four shower stalls, located within the upper and lower resident home areas, were observed to have brownish-yellow staining on and between the tiles.
- Shower Curtains – two of the four showers were observed to have shower curtains with dark brown staining to the lower panel and along the bottom edges of the shower curtain.

Housekeeping Aide #105 and #113 indicated that "high touch surfaces" (e.g. hand rails, and taps) in the tub and shower rooms are cleaned daily by housekeeping staff, but that deep cleans, which would include the scrubbing of the ceramic wall tiles, would only occur if housekeeping staff identified that they needed it. Housekeeping Aide #113 indicated "deep cleans" only happen when housekeeping staff have time to do the task.

Housekeeping Aide (HSKA) #113 indicated that the shower curtains are wiped down daily, as part of the high touch cleaning procedures. HSKA #113 indicated that the shower curtains are disposable; HSKA #113 indicated that he/she believes that the bottom edges of the shower curtains are soiled as the shower curtains drag on the shower floor, as the curtains are too long.

Housekeeping Aides were unable to provide documentation as to when the shower stalls were last cleaned or when disposable shower curtains were last removed and reapplied. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following was observed during dates of this inspection:

- Transfer Grab Bars (home owned) – were noted to have chipped paint, rust and or corrosion on the pole and or base of the said transfer grab bar. The transfer grab bars were observed problematic in identified resident washrooms and in one tub room, located on the upper resident home area, were observed to have rust or corrosion along the base of the said transfer-grab bars.
- Ceramic Wall Tiles – approximately eight wall tiles were observed missing in one of the

upper unit tub rooms; and wall tiles were observed chipped and having "jagged, sharp edges" in one of the lower unit tub rooms.
- In an identified resident room – wall damage was noted, specifically holes in the washroom (approximate two foot length) and exposed dry wall in the same resident's room.
- Counter Top Vanity – the laminate surround was noted gouged or chipped in lounges located in the upper and lower resident home area lounges; and in one tub room in the lower resident home area. The exposed surfaces, which were not covered with laminate, were observed to be porous in nature, which poses challenges with cleaning.
- Nursing Station – the laminate surround, specifically the gate of the nursing station, was observed chipped, gouged or to have pieces of the laminate missing. The exposed surface was not covered with laminate, and was observed to be porous in nature, posing challenges with cleaning.
- Ceiling Tiles – in the identified resident washrooms were observed to have dark brown staining visible.
- In an identified resident room – the veneer surface of the closet door was missing in areas, and observed loose along the bottom edges.

Maintenance Personnel #112 indicated that "all staff when they identify a maintenance concern are to place the identified issue into the maintenance binders, which are located at the nursing stations, so that the maintenance department can fix the problem."

The Maintenance Request Log (binders), located at the upper and lower nursing stations, were reviewed for the period of approximately four months, and failed to identify the above identified maintenance concerns. [s. 15. (2) (c)]

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 there is a process in place and monitored, ensuring the home, furnishings and equipment are kept clean and sanitary; and to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure LTCHA, 2007 s. 24(1) that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Definition of Sexual Abuse, under LTCHA, 2007 s. 2 (1):
-any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Related to intake #014394-16:

A Critical Incident Report (CIR) was submitted to the Director, on an identified date, for an allegation of resident to resident sexual abuse involving resident #041 and resident #045, which was said to have occurred twelve days earlier. Review of the CIR, includes, a note written by the physician, indicating that staff observed resident #041 touching a resident's thigh. The CIR did not identify who that resident was.

Review of progress notes for resident #041 indicated on an identified date, at an indicated hour, RPN #122 documented that resident #041 was touching a resident's upper thigh and reaching for their hand. On a follow up note, written the next day, RPN #122 documented that on an identified date and during specified hours,resident #041 was observed sitting next to resident #043 and placed his/her hand on thigh of the resident, just above his/her knee rubbing it while asking him/her to go home with him/her.

The DOC indicated no awareness of the incident which occurred on the said date; DOC indicated the incident should have been reported, and that the substitute decision makers (SDM) and Police should have been notified. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically as it relates to LTCHA, section 24, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

During this inspection, PT #117 confirmed, with the inspector, that he/she implemented and leads the falls prevention committee in the home. The committee meets once a month and at that time they review all of the falls from the prior month. The committee looks at trends, cause of falls and creates interventions to assist in preventing the falls

specific to the resident; these interventions are placed on the "falls strategies" sign that is posted in the resident's room. PT #117 confirms that it is a multi-disciplinary team that includes PT#117, PTA #118 and any nursing staff from the floors that are able to attend. PT #117 confirms that he/she updates the physiotherapy section of the care plan. This is completed quarterly as per the RAI/MDS schedule and with any changes in status. As well PT #117 confirms that he/she completes the transfer assessment for all residents. PT #117 confirms that he/she does not update the transfer logo in the room, the falling leaf identification logo, or the parts of the care plan related to transfers; this is done by nursing.

PTA #118 confirmed he/she does not update the care plans in PCC, but executes what they say. His/her role is to keep PT #117 updated on resident changes which happen in the home. PTA #118 confirms that he/she is in the home three day a week and PT #117 is in the home two half days a week. PTA #118 confirmed that when he/she is in the home he/she looks to see who has had a fall. PTA #118 confirms that he/she updates PT #117 and when he/she is in the home (twice weekly) then he/she will complete the post falls assessment on the identified residents.

During an interview, PSW #115 indicated that he/she used to be on the falls prevention committee, but is no longer a member. PSW was not certain who was still on this committee other than the DOC, ADOC and PT. PSW #115 confirmed that this committee was meeting monthly, but PSW is unsure if this is still happening. PSW #115 indicated that when he/she was on the committee he/she was responsible for creating the white board that is in the nursing office which identifies residents who have a moderate to high falls risk and utilizes restraints. PSW #115 is unsure if this board is current. PSW indicated that he/she would work with the RN to keep it updated when he/she was on the committee, and that there was one shift a week that PSW #119 was given to ensure that the information was accurate but he/she is not sure if this is still happening. PSW #115 indicated that he/she believed this only happened for a few months.

During an interview, RN #104 indicated that he/she is aware of a falls prevention program in the home but he/she is not part of the team. RN indicated that he/she believes the falls prevention program is overseen by the DOC and ADOC and the team includes physiotherapy as well as PSW's. The Registered Nurses on the floor the day the meeting is taking place are supposed to try to attend the meeting. RN #104 confirms that the registered nurses and the RAI Coordinator are responsible to update the care plan with any changes in resident condition. RN #104 confirmed that when a resident falls it is the homes expectation for the registered nursing staff to assess the resident, document

in the progress notes under falls, complete a risk management assessment in PCC that will generate a referral to physiotherapy so they can assess the resident post falls. If the fall is unwitnessed or if the resident hits their head, then a head injury routine is initiated.

Review of the Falls Prevention Committee Meeting minutes for the home indicates that meetings occurred during two identified months in the current year. The minutes identify ADOC, RAI #100 and PSW #115 as committee members that attended the meeting. No other staffs are identified, including DOC or PT#117 and no other disciplines are represented at the meeting other than nursing.

During an interview with the RAI Coordinator #100, ADOC and DOC, the DOC confirmed that ADOC and RAI Co-ordinator (RAI) #100 printed all of the care plans for current residents and revised them to include the up to date falls interventions. This was completed during the summer of the current year. One PSW on each floor reviewed the paper care plans and updated them to reflect the current care needs for all areas for each resident.

RAI Coordinator #100 indicated that there is a falls prevention program in place but that he/she is not involved in this program. RAI Coordinator believed that this was overseen by two PSW's #115 and #119. RAI #100 confirmed that he/she keeps record of the care plans requiring update based on the quarterly RAI schedule. RAI #100 confirmed that he/she is not updating the care plan with a change in status for residents; this is captured at the quarterly review. RAI Coordinator indicated that he/she was not aware that he/she was responsible for monitoring to ensuring that care plans are kept current and are reflective of the care needs for the residents. RAI Coordinator confirmed that he/she was unaware of the contents of the Action Plan submitted to the Ministry of Health and LTC, and he/she was unaware that he/she is identified as the person responsible for completing the actions outlined in the plan.

ADOC indicated that it is the homes expectation for the registered nursing staff to ensure that the RAI Coordinator is kept updated of a change in status so that the care plan can be updated. ADOC confirmed that the registered nurses could update the care plan when a residents care needs change but at the very least they are to inform the RAI Coordinator so that he/she can ensure the care plan is updated.

The ADOC confirmed that all staff were educated on the Falls Preventions & Management policy VII-G-60.00. The education was conducted in two ways; verbal or as a read and sign. The policy changes were also discussed at staff meetings. The policy

Falls Prevention & Management VII-G-60.00 was then uploaded onto Surge learning during an identified month. The organization expects that all nursing staff will have completed this training by the end of 2016 to meet the homes annual education requirements. Education records provided indicate that all nursing staff with the exception of one PSW has received the training in 2016. ADOC confirmed that an auditing tool was created to monitor the falls prevention program in the home. Audits of four random falls that occurred in previous month, were completed. The assessments were reviewed to confirm the documentation was reflective of the care that is being provided and to verify that the care plan was updated. ADOC indicated that this has only been audited once, gaps were identified during the audit. The ADOC indicated that he/she has not had the opportunity to report the findings back to the staff for feedback.

DOC confirmed that the homes expectation for when a resident falls is that the registered nurse will complete an assessment of the resident, document the incident in detail in a progress note and complete a falls incident report under Risk Management in PCC. Physiotherapy will complete a post falls assessment of the resident. The DOC indicated that she reviews the risk management in point click care on a weekly basis to read and sign off the incidents that have been documented in the home. The DOC confirmed that the RAI Coordinator is responsible for monitoring to ensure that care plans are kept current and are reflective of the care needs for the residents; the DOC confirms she is aware that this has not been happening.

DOC confirms that the falls prevention program "Fall Leaf" was re- introduced in the home in April 2016. The DOC indicates that the falls committee meetings were happening as part of the resident safety committee. The meetings were held during two identified months, but have not occurred since. DOC confirmed that going forward, the ADOC will take over the resident safety committee meetings, which will capture "falls prevention as an area of focus". DOC indicated that at this time they are unsure who will actually attend the falls prevention committee, the intent is that it will be multi-disciplinary but at this time it does not appear to be. The DOC confirmed that at this time there is a policy to support the falls prevention program, but that only pieces of the program are being implemented in the home and that the program is not being monitored.

Therefore the licensee has failed to ensure that there is an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury. [s. 48. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring there is an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or in a medication cart that is secure and locked.

The noon medication administration pass, was observed on an identified date during this inspection; the following was observed:
- A medication cup, containing medications, specifically a round white pill, oblong white pill, a brown pill and a green capsule were left unattended at table #4 in the dining room; the medication cup was labelled, using a hand written label, identifying that medications were for resident #047 (last name only). Resident #047 was not present at the table

during this observation.
- A medication cup, containing medications (3 pills and 4 capsules), was left unattended at table #7 in the dining room; the medication cup was labelled, using a hand written label, identifying that medications were for resident #026 (first name only). Resident #026 was not present at the table during this observation.
- A medication cup, containing medications, specifically two round white pills, and an oblong white pill , was left unattended at table #7 in the dining room; the medication cup was labelled, using a hand written label, identifying that medications were for resident #021 (first name only). Resident #021 was not present at the table during this observation.
- A medication cup, containing medications (one white round pill) was left unattended at table #3 in the dining room; the medication cup was labelled, using a hand written label, identifying that medications were for resident #023 (last name only). Resident #023 was not present at the table during this observation.
- A purple diskus inhaler was observed lying on table #5 in the dining room; the inhaler had a pharmacy label, in which the said medication was prescribed for resident #046. Resident #046 was not present at the table during this observation, but arrived a short time later.

The medications observed on the dining room tables, matched medications perscribed by each identified resident's physician and the corresponding eMAR (homes electronic medication administration record) for each of the said residents, indicated above.

Resident #042, who is cognitively impaired, was observed wandering about the dining room during the above observations.

Registered Nurse (RN) #109, who was the Charge Nurse, and who was administering the above medications on the identified date, indicated "being aware that medications were not to be left unattended" and further indicated "being aware that drugs were to be kept in a secured location when registered nursing staff were not in attendance".

Registered Nurse #104, who is also a Charge Nurse, indicated "medications are at no times to be left unattended with residents, unless the said resident has a physician's order for self-administration". RN #104 indicated that residents #021, 023, 026, 046 and 047 are not permitted to self-administer medications.

Director of Care indicated "medications are not to be left unattended and such are to be secured and locked in the medication room or medication cart when a nurse is not

present". [s. 129. (1) (a)]

2. Resident #009 was observed by Inspector #623 on an identified date, to have four different medications in his/her room. There were 4 bottles of a specific vitamin with 365 tablets per bottle. Three of the bottles that were unopened, were kept on an open shelf on a table beside his/her bed, and the other opened bottle was on the window sill. There was an opened bottle of another vitamin, containing 100 tablets that was observed on the window sill as well. A bottle of 72 tablets of antacid was observed on the open shelf under the table beside the bed and a container of analgesic cream was on top of that table. There were no prescriptions attached to any of the bottles (observed). Resident #009 had no orders for the use of the antacid and the analgesic cream.

Resident #009 had physician's orders for the identified vitamins, which indicated the dosage and frequency; the physician's order further indicated "may use own supply". There were no orders from the physician stating that the resident could have these medications at his/her bedside and self-administer them.

Resident #021 was observed by Inspector #623 on an identified date to have identified eye drops on top of his/her bedside table. The resident stated that he/she used the eye drops on a daily basis. Resident #021 had no orders from the physician for the use of the identified eye drops.

Inspector #632 interviewed RPN #107, who stated that he/she knew resident #009 had specific vitamins in his/her room, but was unaware that he/she had the other medications in his/her room, as well. Inspector #632 also interviewed RN #104 as to the medication. The RN stated that he/she was not aware that resident #021 had the identified eye drops in his/her room and that the resident didn't have an order for them. RN stated that the resident should not be taking these drops on his/her own, and he/she should not have them in his/her room.

The licensee has failed to ensure that drugs are stored in an area that is secure and locked in relation to those medications stored in open areas in resident #009 and #021's rooms. [s. 129. (1) (a)]

3. The licensee failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On an identified date, during this , during the noon medication administration pass, the following was observed:
- A medication cup, containing medications, specifically a round white pill, oblong white pill, a brown pill and a green capsule (with black numbers and lettering) were left unattended at table #4 in the dining room; the medication cup was labelled, using a hand written label, identifying that medications were for resident #047 (last name only). Resident #047 was not present at the table during this observation.

Registered Nurse #109, who was the charge nurse, as well as medication nurse on the identified date, indicated "being aware that drugs are not to be left unattended".

RN #104 confirmed that the green capsule with black lettering and numbers, observed in the medication cup on the identified date, would be "the identified controlled substance", which is prescribed for resident #047.

RN #104 and the Director of Care indicated "it is not the policy or practice of the home to leave drugs of any kind unattended". Both further indicated "drugs, including controlled substances are to be kept locked and secured". RN #104 indicated "controlled substance are to be double-locked". [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that drugs are stored in an area or in a medication cart this is secure and locked; that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

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

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

s. 131. (6) Where a resident of the home is permitted to administer a drug to himself or herself under subsection (5), the licensee shall ensure that there are written policies to ensure that the residents who do so understand,
(a) the use of the drug; O. Reg. 79/10, s. 131 (6).
(b) the need for the drug; O. Reg. 79/10, s. 131 (6).
(c) the need for monitoring and documentation of the use of the drug; and O. Reg. 79/10, s. 131 (6).
(d) the necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on his or her person or in his or her room under subsection (7). O. Reg. 79/10, s. 131 (6).

Findings/Faits saillants :

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

Resident #009 was observed by Inspector #623 on an identified date, to have a bottle of 72 tablets of antacid on an open shelf under the table beside the bed and a container of analgesic cream was on top of that table. When interviewed by the Inspector, resident #009 stated that he/she used the analgesic cream every day, and that he/she took the antacid almost daily.

Resident #021 was observed by Inspector #623 on an identified date to have specific eye drops on top of his/her bedside table. The resident stated that he/she used the drops on

a daily basis.

Inspector #641 reviewed resident #009 and #021's Medication Administration Record for an identified month, as well as physician's orders; resident #009 did not have a physician's order for either the antacid or the analgesic cream and resident #021 did not have an order prescribed for his/her for the identified eye drops.

Inspector #623, interviewed RPN #107, who stated that he/she was not aware that resident #009 had both the analgesic cream and the antacid in his/her room. Inspector #623 also interviewed RN #104. RN stated that he/she was not aware that resident #021 had the eye drops in his/her room and that the resident didn't have an order for them. RN stated that the resident should not be taking these eye drops on his/her own, and he/she should not have them in his/her room.

The licensee has failed to ensure that resident #009 and #021 have prescriptions for all the medications that they are receiving. [s. 131. (1)]

2. The licensee failed to ensure that drugs are administered in accordance with the directions for use specified by the prescriber.

Related to Resident #046:

Resident #046 has a physician's order for an identified inhaler; the drug is to be administered one puff inhale two times daily for indicated use. The eMAR (electronic medication administration record) identifies times of administration for the said inhaler to be 0800 hours and 1800 hours.

On an identified date, during the noon meal, RN #109 left the identified inhaler on table #5. Resident #046 was observed self-administering the drug and handing the inhaler to the Director of Care, who was in the dining room.

According to the eMAR record, RN #109 had administered the identified inhaler to resident #046 at a specific time on the identified date; the next administration time was scheduled for 1800 hours on that same date. [s. 131. (2)]

3. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the perscriber in consultation with the resident.

On an identified date, inspector #570 observed resident #009 had the following items on the window sill in his/her room;

- 1 open bottle of an identified vitamin (no prescription label)
- 1 open bottle of a second identified vitamin (no prescription label)

On an identified date, inspector #623 observed that resident #009 had the following items in his/her room;

- On the window sill - 1 open bottle of an identified vitamin, no prescription label (365 tablets per bottle)
- On the window sill - 1 open bottle of second identified vitamin, no prescription label (100 tablets per bottle)
- On the lower shelf of the bedside table - 3 unopened bottles of a vitamin (365 tablets per bottle) -no prescription label
- 1 opened bottle of antacid (72 tablets per bottle) - no prescription label
- On the top of the bedside table - 1 tube of analgesic cream - no prescription label.

During an interview, resident #009 indicated that he/she keeps these items in his/her room and at his/her bedside. He/she stated that his/her son/daughter brings them to him/her when he/she requests. Resident stated that he/she takes the identified vitamin "all the time, whenever he/she thinks of it". Resident was observed by inspector putting two tablets in his/her mouth from the labelled bottle. Resident stated that he/she has the other vitamins in his/her room but he/she doesn't take it anymore. Resident #009 indicated that the antacid he/she "uses when he/she needs them, almost every night" and the analgesic cream he/she "applies it every morning".

Review of the physician orders for resident #009 indicated the following;
An identified vitamin - take one tablet daily (government supply contained in strip packaging)
Another identified vitamin – give 1 capsule by mouth one time a day for indicated use (resident has own supply)
A third vitamin – give by mouth one time a day for indicated use (may use own supply)
There are no written orders for analgesic cream or antacid.

During an interview RPN #107 confirmed that resident #009 family supplies the identified vitamins for the nursing staff to administer to the resident as ordered. RPN was able to

show the bottle to the inspector. Noted that there is no prescription label on the bottle and that resident #009's last name is written on the bottle in black marker; RPN #107 confirmed that this is the bottle he/she used to administer the medication to resident #009 today. RPN #107 also confirmed that resident #009 has an order for the identified vitamin and that the family supplies the medication (vitamin). RPN #107 indicated that resident #009 keeps the bottle of identified vitamin in his/her room and that he/she self-administers the medication. RPN#107 confirmed that he/she signs the electronic medication record (eMAR) indicating that the medication was administered but that he/she does not actually give the identified vitamin to resident #009. RPN stated that he/she does not ask resident #009 if he takes the medication, he/she just assumes that he/she has taken it and signs the eMAR. RPN#107 confirmed that resident #009 receives another identified vitamin in the strip packaging and that this is administered every morning at a indicated time to the resident. RPN indicated that he/she was unaware that resident was also taking the same vitamin in his/her room from his/her own supply. RPN also confirmed that he/she was unaware that resident #009 had the antacid and analgesic cream at the bedside. RPN#107 stated that it is common practice for families to supply medications like vitamins for residents.

On an identified date, inspector #623 observed that resident #021 had a bottle of an identified eye drops on the bedside table. The bottle of eye drops did not have a prescription label on it indicating that it was dispensed by pharmacy.

During an interview resident #021 confirmed that this bottle of eye drops was supplied by his/her family and that he/she uses the drops every day. Resident #021 indicated that he/he did not tell the nursing staff when he/she uses the eye drops and he/she was unsure if they were aware that he/she had them at the bedside.

Review of the clinical records including physician orders and medication administration records for resident #021 indicated that there is no physician order for the identified eye drops.

During an interview RN#104 confirmed, with the inspector, that resident #021 does not have an order for the identified eye drops. RN indicated that resident #021 should not be self-administering medications and that he/she was unaware that resident #021 had eye drops at the bedside.

The licensee failed to ensure that resident #009 and #021administers a drug to themselves unless the administration has been approved by the prescriber in

consultation with the resident. [s. 131. (5)]

4. The licensee has failed to ensure that where a resident is permitted to administer a drug to himself or herself that there are written policies to ensure that the residents who do so understand:
a) the use of the drug.
b) the need for the drug
c) the need for monitoring and documentation of the use of the drug, and
d) the necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on his or her person or in his or her room.

Resident #023 has a history that includes cognitive impairment. On an identified date, resident was observed to have a prescription bottle of an identified eye drop at his/her bedside table.

The label reads:
Identified Eye Drops - one drop when needed may keep at bedside.

During an interview, during this inspection, resident #023 confirmed, with the inspector, that he/she keeps this medication at his/her bedside and usually administers the eye drops to him/herself three times a day. Resident #023 indicated that he/she does not report to the nurse when he/she uses the medication, only when it is empty and he/she needs more. Resident indicated that he/she does not have a secured place to store the medications. Resident #023 indicated that there are also other medications that he/she keeps in his/her room but could not recall what they were. Resident #023 did however reveal that they were for his/her eyes and nose. Resident was not willing to show these medications to the inspector and they were not visible at the time of inspection.

Review of the physician orders for resident #023 indicates the following medications "may be kept at bedside" as ordered by the physician; specific to the identified medications.

Review of the medication administration record, for a specific time period, for resident #023 reveals that the medications identified as "resident keeps at the bedside" or "may self administer" are listed as PRN (as needed) and there is no record that resident has received, the identified medications, during the identified period.

During an interview, during this inspection, RN #104 confirmed, with the inspector, that

resident #023 had prescription treatments at the bedside. RN indicated that resident #023 self administers the medications when he/she feels that he/she requires them, but does not tell the nursing staff when he/she is taking them and does not keep a record of the medication use. The registered nurse is only notified by resident #023 when the container is empty and the resident is requesting a refill. RN #104 indicated that resident #023 keeps the medications in his/her room, usually on his/her bedside table and to his/her knowledge they are not secured. RN#104 indicated that he/she is not aware of an assessment that has been completed for resident #023 to ensure that he/she is capable of self medicating and safeguarding any medications that are left at the bedside. RN#104 indicated that he/she was not aware if the home has a policy for residents self administration of medications.

Review of the home's policy, #4-007 Resident Self Administration of Medication
Policy: For residents who wish to self administer medication(s), the following criteria are to be followed:
- obtain a doctors order authorizing staff to leave medication(s) at the bedside of resident.
- ensure resident is capable of self administration of medication(s)
- ensure safe and proper storage of medication(s) to protect integrity of medication and to restrict access to anyone other than the resident.

Procedure:
1. An order from the physician must be obtained to provide authorization for a staff member to leave medication(s) at bedside of a resident deemed capable of self administering of medication.
2. The resident who makes a request to have medication(s) left at the bedside should be assessed on an ongoing basis, to be determined by facility (at least annually), by registered staff (i.e.RN, RPN) or physician and pharmacist to ensure that they are capable of self medicating and safeguarding any medication(s) left at bedside.
3. A copy of this evaluation of the resident should be kept in the chart.

Review of clinical medical records for resident #023 including the paper chart and electronic documentation, failed to reveal an assessment or evaluation to determine capability of self-medicating and safeguarding any medications left at the bedside. The care plan in point click care does not identify that resident may self administer medications.

During an interview, during this inspection, the DOC confirmed that the licensee does

have a policy for residents who wish to self administer medications. The homes expectation is that this policy is followed to determine that a resident is capable of safely administering and safely storing medications and that registered nurses would be monitoring the use of the medication. DOC indicated that she is not aware of any residents that are self administering medications in the home at this time. [s. 131. (6)]

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 there is a process in place and monitored, ensuring that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident; that drugs are administered in accordance with the directions for use specified by the prescriber; that no resident administers a drug to himself or herself unless the administration has been approved by the perscriber in consultation with the resident; and that where a resident is permitted to administer a drug to himself or herself that there are written policies to ensure that the residents who do so understand, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participates in the implementation of the infection prevention and control program.

The organization's policy "Hand Hygiene" (not numbered) directs the following:
Hand Hygiene is the responsibility of all individuals involved with health care and must be performed at the four moments for Hand Hygiene:
1) Before initial patient and patient environment contact
2) Before aseptic technique
3) After blood or body fluid exposure/risk
4) After patient and patient environment contact

The following was observed on an identified date, during the noon medication administration pass:
- Registered Nurse (RN) #109 was observed administering noon medications to four residents; during this observation RN #109 spooned medication into each resident's mouths, using separate utensils; assisted two of the residents to consume fluids; and wiped two residents faces with tissue; RN then placed the soiled tissue onto the medication tray he/she was carrying; RN #109 then walked down the hall into a resident's room, assisted that resident into the washroom (while still holding medication tray containing medications), walked out of the room and back down the hallway, and into the dining room. RN #109 then administered eye drops to a resident sitting at table #3 in the dining and then continued to administer pre-poured medications from a tray. During the said observations, RN #109 was not observed performing hand hygiene.

The Director of Care indicated that RN #109 has completed the organization's infection prevention and control annual training, specifically as such relates to hand hygiene. The DOC provided the inspector with a copy of the Surge Learning Workbook (electronic learning tool) specific to RN #109; the workbook provided confirmation that RN #109 had completed "Hand Hygiene" re-training in January of 2016.

The Infection Prevention and Control Lead indicated that "it is an expectation that all staff perform hand hygiene according to the four moments of hand hygiene" which includes between residents during medication administration. [s. 229. (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 there is a process in place and monitored, ensuring that all staff participates in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Related to intake #014394-16:

Critical Incident Report (CIR) was submitted to the Director, on an identified date, for an allegation of resident to resident abuse, involving resident #041 and resident #045, that occurred approximately twelve days earlier. The CIR indicated the allegation was reported to the Director, two days later, using the after hours pager.

Review of the home's policy, Abuse and Neglect of a Resident-Actual or Suspected (#VII-G-10.00) directed the following:
- if a staff member or volunteer becomes aware of potential or actual abuse, be it by a staff member, volunteer, family member, co-worker, the following steps must be taken: (1) safeguard the resident immediately (2) notify the Charge Nurse; the Charge Nurse will, notify the RN in charge of the home, immediately notify the DOC/Administrator, initiate the Nursing Checklist for Reporting and Investigating Alleged abuse, assess and

evaluate injuries and document each shift for a minimum of 72 hours post incident.
-the Administrator or designate will: obtain written statement from concerned parties including the resident if he/she is able, notify the police to investigate an alleged sexual abuse of if there has been an injury from an assault or when any other criminal activity has taken place, as soon as possible after the investigation, continue completion of Nursing Checklist for reporting and Investigating Alleged Abuse, provide referral information and offer to arrange additional emotional counselling and support from a recognized professional social worker, psychologist, clergy or other recognized person to the resident.

Review of progress notes, for resident #041, indicated that on the identified date, RPN #122 documented that during shift report resident #041 exhibited specific responsive behaviours . Resident #041 was sitting next to resident #045, when resident #041 hit resident #045. Later that shift, RPN #122 documented that resident #041 was uttering threats regarding other residents and resident #045 told PSW staff that resident #041 expressed harm to him/her. Both residents were separated and monitored.

On an identified date, the DOC indicated that RPN #122 did not report the incident of resident to resident physical abuse that occurred on the identified date to the RN, or the DOC as per policy. The incident was noted two days later, when RN #104 reviewed the notes and once the incident was noted by the RN, a CIR was completed and the MOHLTC was notified. POA's were notified. The DOC further indicated that Police were not notified of the incident and that the police should have been notified. The DOC confirmed that the abuse policy was not complied with when RPN #122 did not report the incident to the charge nurse on the identified date. [s. 20. (1)]

2. The licensee has failed to comply with s. 20 (1) by not ensuring the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Related to residents #006 and #040:

Review of progress notes for resident #040 indicated an entry by RN #104, indicating that on an identified date, housekeeper staff #126 walked into resident #040's room and witnessed resident #006 and resident #040 sitting with their shirts off and resident #006 had both of his/her hands on resident #040's chest. Both residents covered themselves when housekeeper entered the room and resident #006 left the room. RN reinforced importance of reporting observations when such occurs.

Interview with the DOC indicated, to inspector #570, he/she had no awareness of the incident occurred on the identified date, that was reported RN #104. The housekeeping staff who discovered the incident on the identified date should have immediately reported it to the charge nurse as per policy. The incident should have been reported to the Director.

The licensee's policy on abuse prevention was not followed when staff #126 did not report the incident when discovered on the identified date. The incident was reported to the change nurse two days later by, another staff #113; the DOC was not notified, and no investigation was completed; the incident was not reported to the Director.

At the time of the above described incident, the licensee had an outstanding compliance order (#002) in place, specific to LTCHA, 2007, s. 20 (1) (b), which had an identified compliance due date. All incidents described occurred prior to this date. [s. 20. (1)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to minimize the restraining of residents is complied with.

Under LTCHA, 2007, s. 29 (1) (a), every licensee of a long-term care home, shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with the Act and the regulations.

The home's policy, Restraint Implementation Protocols (#VII-F-10.08) directs the following:

Registered Nursing Staff will:
- Maintain a list of residents requiring restraints on each shift.
- When a restraint is identified as a need for a resident, implement immediate safety precautions for all concerned.
- Add "restraint monitoring" to task list on PCC-POC (home's electronic resident flow record) and review at the end of each shift to verify accurate Personal Support Worker (PSW) documentation and communication.
- Revise the care plan as required.
- Resident's condition is to be reassessed and the effectiveness of the restraining evaluated at least every eight hours and at any other time when necessary based on the resident's condition or circumstances. Document/sign restraint use on PCC eMAR (home electronic medication administration record).
- Review and document all restraint orders, interventions, resident responses, outcomes and decisions to implement, continue, or discontinue the restraint, quarterly and with any changes in the resident condition.

The Personal Support Worker will:
- Review the resident's care plan and follow recommended interventions.
- Apply the restraint according to instructions specified by the physician. Document on PCC-POC.
- Observe and monitor the resident needs.
- The resident is to be monitored every hour as directed by the regulated staff for safety, comfort and position. Document resident response and care provided on PCC-POC.
- Release the restraint every two hours and reposition the resident before reapplying the restraint and any other time when necessary based on resident's condition and or circumstances.

Related to Resident #039:

Resident #039 has a history which includes cognitive impairment. Resident #039 is at known risk for falls and is dependent on staff for activities of daily living. Resident #039 was observed during dates of this inspection, to be sitting in an identified mobility aid (chair) with a restraint in place. Resident #039 could not unfasten the restraint when asked to do such by the inspector.

During dates during this inspection, Personal Support Worker (PSW) #103 and Registered Nurse (RN) #101 indicated, to the inspector, "resident #039 uses an identified

mobility aid with a restraint on a daily basis, whenever resident is not in bed". PSW #103 and RN #101 both indicated "resident #039 has been using a chair with restraint since mid-August 2016". Both indicated "resident cannot unfasten the restraint".

Personal Support Worker #103 and RN #101 indicated "all restraints are to be monitored hourly with documentation (hourly) on POC" (point of care, the home's electronic resident flow sheet record).

During this inspection, Personal Support Worker #103, along with the inspector, reviewed the restraint monitoring task on POC. The POC task for restraint monitoring indicated "Restraint Use – PRN restraint in identified mobility aid if needed for increased risk of falls due to fatigue/unsteadiness with frequent wandering/walking. Please document every hour if in use."

There is no documentation, in POC or other records in resident #039's clinical health record, to support that direct care staff were providing hourly monitoring, of the restraint being used for resident #039 specific to the dates in the identified period, as per the home's policy Restraint Implementation Protocols.

Registered Nurse #101 and RAI-C both indicated that the restraint monitoring record on POC was not reflective of resident #039 care needs. Both acknowledged that resident #039's care needs had changed following a fall on an identified date, and that the restraint monitoring record on POC was not reflective of this change.

Upon further record review, the following was noted by the inspector:
- There was no hourly documentation of restraint monitoring, for resident #039, during the period of reviewed (one month);
-The plan of care (care plan, with an identified review period) indicated "an identified restraint was used PRN, when resident is wandering or appearing tired or fatigued";
-The last assessment specific to "restraint use" was dated two months earlier and such indicates "resident was using two assistive devices while in bed". This assessment indicated "the identified restraint was not in use, while in the chair".

The licensee failed to ensure that the written policy to minimize the restraining of residents is complied with, as evidenced by:

Registered Nursing Staff did not:
- Ensure that resident #039 was monitored at least every hour, while restrained; nor was

there documentation to support, that during the period reviewed (one month), registered nursing staff monitored resident #039 at least every eight hours while the resident was restrained.
- Revise the plan of care, when there was a change in resident #039's health status and or care needs.
- Review and document all restraint orders, interventions, resident responses, outcomes and decisions to implement, continue, or discontinue the restraint, quarterly and with any changes in the resident condition, as it relates to resident #039. The last assessment on file for this resident, does not include use of an identified restraint, for resident #039.

Personal Support Workers did not:
- Document hourly resident response and care provided. There is no documentation on POC during the period reviewed (one month)

The Director of Care indicated it is the expectation that all nursing staff are following the home's policy Restraint Implementation Protocols. [s. 29. (1) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse of a resident.

Related to Intake #025968-15, for Resident's #041 and #042:

The Director of Care submitted a Critical Incident Report (CIR) on an identified date, to the Director, as described under the Long-Term Care Homes Act (LTCHA), with regards to resident to resident sexual abuse. The incident was said to have occurred approximately five days later and was immediately reported to the Director on the same date.

According to the CIR, clinical health record review for residents #041 and #042 and interviews with Registered Nurse (RN) #104 and the Director of Care, the following was said to have occurred on the identified date.

Resident #042 was asleep in the lounge. Resident #041 was observed, by a visitor, inappropriately touching resident #042 while he/she slept. Resident #042 woke during the interaction and was said to give resident #041 a "funny look". The visitor sought the aid of staff, both residents were separated.

The witnessed sexual touching incident by resident #041 towards resident #042 was reported by personal support worker to Registered Nurse (RN) #104.

Registered Nurse #104 indicated that resident #042 did not consent to the touching by resident #041, as resident #042 was asleep at the time of the interaction; the incident would be seen as "sexual abuse".

Registered Nurse #104 indicated "the police were not notified of the incident on the identified date, as the Substitute Decision Maker (SDM) of resident #042 did not believe a police report was necessary as both residents have a cognitive impairment".

The Director of Care indicated that "RN #104 should have contacted police on the identified date, regarding the witnessed sexual abuse incident".

At the time of this inspection, the local police authority had not been contacted with regards to the identified witnessed incident of sexual abuse between residents #041 and #042. [s. 98.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the Director was immediately informed of an unexpected or sudden death.

Related to Intake #025215-16, for Resident #043:

The Director of Care submitted a Critical Incident Report (CIR) to the Director, as described under the Long-Term Care Homes Act (LTCHA), on an identified date.

According to the CIR, as the clinical health record for resident #043, nursing staff found resident #043 deceased, on an identified date and time. The death of resident #043 was deemed by registered nursing staff and the physician as "unexpected".

Director of Care confirmed that the Director was not notified of the unexpected death of the resident for two days.

The Director of Care indicated that Registered Nurse #104, who was the Charge Nurse on the identified date, should have reported the unexpected death using the after-hours number.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident unless the drug: a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply, and b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario.

Review of the physician orders for resident #009 indicated that two specific vitamins were ordered for the resident. Physician's orders identified the vitamin, dosage and frequency, and that resident may use own supply.

Review of the medication administration records, for an identified month, for resident #009 indicates that the two vitamins ordered are signed daily indicating that they have been administered to resident #009.

During an interview, RPN #107 confirmed that resident #009's family supplies one of the identified vitamins for the nursing staff to administer to the resident as ordered. RPN #107 also confirmed that resident #009 has an order for a second identified vitamin that the family supplies. RPN #107 indicated that resident #009 keeps the bottle of the identified vitamin in his/her room and that he/she self-administers the medication. RPN #107 confirmed that he/she signs the electronic medication record (eMAR) indicating that the medication was administered but that he/she does not actually give the identified vitamin to resident #009. RPN stated that he/she does not ask resident #009 if he/she takes the medication, he/she just assumes that he/she has taken it and signs the eMAR.

RPN #107 stated that it is common practice for families to supply medications like vitamins for residents. RPN confirms that he/she administers medications that are ordered for resident #009 and supplied by the family.

During an interview, DOC indicated that families have been known to bring items in, including over the counter medications for residents. DOC was unable to confirm exactly which resident's families are doing this but that there are probably a few. DOC indicated that she was aware that the registered nurses were administering medications that were supplied by the families. DOC indicated that the long-term care home contracts a specific pharmacy.

Therefore the licensee has failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident unless the drug, has been provided by, or through an arrangement made by, the pharmacy service provider of the Government of Ontario. [s. 122. (1)]

Issued on this 28th day of October, 2016

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

Original report signed by the inspector.