Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 6, 2018	2018_601532_0014	016626-18, 016630-18	Follow up

Licensee/Titulaire de permis

LaPointe-Fisher Nursing Home, Limited
1934 Dufferin Avenue WALLACEBURG ON N8A 4M2

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

LaPointe-Fisher Nursing Home
271 Metcalfe Street GUELPH ON N1E 4Y8

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

NUZHAT UDDIN (532)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): July 19, 20, 2018.

A Written Notification and Compliance Order related to LTCHA, 2007,c.8, s. 6(7), identified in a complaint inspection 2018_580_568_0008 (Log #006193-18 / IL-56233-CW and Log #005822-17 IL-49864-Log #005822-17/IL-49864-LO) were issued in this report.

A Written Notification and Compliance Order related to LTCHA, 2007, O.Reg.79/10,s.8.(1)(b) identified in Critical Incident System Inspection (CIS) 2018_580568_0009 Log # 025073-17, Log #005914-17 and Log # 021646-17 were issued in this report.

A Written Notification and Compliance Order related to LTCHA, 2007, O.Reg.79/10,s.8.(1)(b) identified in a Complaint inspection 2018_580568_0009 Log #006193-18 / IL-56233-CW related to care plan and air conditioning. Log #005822-17 IL-49864-Log #005822-17/IL-49864-LO related to multiple care issues i.e. nail care, bathing, continence care and bowel management, infection control, housekeeping, transfer and positioning techniques.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, associate Director of Care, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and Residents.
Inspector also toured the resident home areas, observed resident care provision; resident/staff interaction, reviewed relevant resident's clinical records, relevant policies and procedures, medication administration observation as well as notes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Skin and Wound Care

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

6 WN(s)
1 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

a) Review of identified resident's weights indicated that there was a significant weight change.

The Registered Dietitian (RD) documented in a follow-up assessment that there was a significant weight change in the past month. Strategies were identified to address the weight loss and it included interventions.

An identified Personal Support Worker was observed passing out afternoon nourishment to residents. Inspector checked the nourishment cart and did not observe the intervention for the identified resident.

Review of identified resident's record indicated that there was no documentation that the resident was to have the intervention.

The FSM acknowledged that the RD had documented in a progress note regarding the identified resident's intervention, however, the FSM missed to update the diet sheets and the care plan to include the intervention.

b) A complaint submitted to the Ministry of Health and Long Term Care (MOHLTC) identified concerns regarding personal care.

Observation showed that personal care was not done and this was confirmed by an identified PSW.

Review of the identified resident's record indicated that they had responsive behaviours

related to their diagnosis.

Resident's records stated that personal care was to be checked and completed as needed on a daily basis.

Identified PSWs and RPNs all confirmed in interviews that the specified resident was resistive to having their personal care done.

Interventions were outlined in the care plan when the identified resident refused the personal care and their family was to be contacted to elicit family input for the best approaches to take with the identified resident.

Record review of resident progress notes did not indicate that the resident's SDM / family was notified about the resident's refusal to have personal care done as indicated in the resident's written care plan.

The Administrator stated that the care plan for the identified resident had not been followed with respect to personal care.

c) An identified resident's care plan stated that they were at high risk of falls and further interventions were identified.

The resident was observed lying in bed on three different identified dates and the interventions were not in place and this was acknowledged by a PSW.

DOC acknowledged that the interventions were not in place and the care set out in the plan of care was not provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care for the identified residents was provided to the residents as specified in their plan. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

In accordance with Ontario Regulation 79/10, s. 49.(1) the licensee was required to ensure that there was a falls prevention and management program that included strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Specifically, staff did not comply with the home's Falls Prevention and Management policy, ”Part B: Post Fall Assessment and Management” effective March 2, 2011, and revised January 30, 2015.

a) Critical Incident Report and record review for an identified resident reported that they had an un-witnessed fall. The resident was taken to hospital where they received interventions.

There was no evidence in the clinical record that a post fall assessment and head injury routine had been completed for the fall. This was verified by an identified RPN.

b) Critical Incident Report and record review for another identified resident reported that they had an un-witnessed fall which resulted in a transfer to hospital for a possible injury and had another un-witnessed fall on an identified date.

During an interview the DOC confirmed that post fall, a post fall huddle form would come to the DOC's office where they were reviewed and recommendations developed.

However, DOC stated that they did not have any post fall huddle reports for the identified fall.

DOC stated that there were no head injury routine for the identified resident after their un-witnessed falls.

c) Critical Incident Report and record review for an identified resident reported that resident had an un-witnessed fall which resulted in an injury and transfer to hospital.

DOC stated that they do not have any post fall huddle reports for identified date.

RPN/RAI reported that there were no documents found for a head injury routine assessment or for the post fall huddles for the identified resident after their un-witnessed fall.

The licensee has failed to ensure that the home's Falls Prevention and Management policy was complied with in relation to identified resident's fall. [s. 8. (1) (a),s. 8. (1) (b)]

2. In accordance with Ontario/Regulation 79/10, s. 48.(1)(2) the licensee was required to ensure that 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 was developed and implemented.

Specifically, staff did not comply with the licensee's policy regarding "Skin and Wound Care" section S, dated as revised March 4, 2016.

Review of weekly skin assessment showed that the identified resident had altered skin integrity.

Record review showed that there were missing weekly assessments for the identified dates.

Registered Nurse (RN) stated that the RNs were to complete the assessment (initial and weekly), Treatment Administration Record (TAR) review, and communication note for the physician, the care plan, progress notes and update the treatment.

RN acknowledged that there were missing assessments under the assessment tab in PCC and referred the Inspector to Wound Care Champion.

Wound Care Champion (WCC) checked the TAR for documentation for the altered skin integrity and were not able to find the missing weekly wound assessments.

Associate Director of Care (ADOC) acknowledged that the skin assessment was not done on a weekly basis for the identified resident. They indicated that they found that the registered staff were documenting multiple skin and wound issues into one assessment and were not making notes regarding improvement or deterioration. The ADOC reported that the tool that staff were currently using did not indicate if the wound was improving or deteriorating. They said that the assessment was not based on best practice.

The licensee has failed comply with the "Skin and Wound Care" policy specifically weekly skin and wound assessment. [s. 8. (1) (a),s. 8. (1) (b)]

3. In accordance with Ontario/Regulation 79/10, r. 114. (2) the licensee was required to ensure that written policies and protocols were 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.

Specifically, staff did not comply with the licensee's policy regarding "Administration of Medication- Oral Medication" Section M, Page 2.6, dated as reviewed March 4, 2016.

It was observed that an identified RPN prepared the medication for administration for an identified resident and initialed the medication administration record (MAR) sheet as given before it was offered to the resident.

It was observed that the identified RPN prepared the medication for administration and gave the drug to an identified resident in their hand and walked away. RPN did not ensure that the resident took the medication. The RPN was observed preparing medication for another resident and did not go back to ensure that the identified resident took the drug. RPN was observed documenting on the medication administration record that the drug was given, however, the resident had not taken the medication until later. The resident was observed holding the medication for few minutes before ingesting it.

The care plan for the identified resident stated, encourage the resident to take medications but did not identify for them to self-administer medication.

It was observed that an identified RPN prepared a drug for another identified resident,

and placed it on the table in front of them and walked away. The RPN was observed going back to the cart and initialing the medication administration record sheet as drug was given. However, the resident kept the medication to the side and did not take the medication right away. The RPN was not observed encouraging the resident to accept staff administering the drug, and were noted that they had moved on to the next resident while the drug was still sitting on the dining table. The identified resident was sharing the table with co-resident.

The plan of care for identified resident stated, encourage the resident to accept staff administering drugs.

An identified RPN acknowledged that they signed for medication prior to administering it as they had worked in the home for a long time and knew the residents. The identified RPN reported that they followed the practice of signing the medication record before administering medication. They explained that if the resident refused they would go back and cross off the medication administration and would make a progress note afterwards.

DOC acknowledged that the practice was to sign after the medication was administered to ensure that residents took the medication and staff were to stay with the resident until medication was swallowed.

The licensee has failed to ensure that policy regarding "Administration of Medication-Oral Medication" was complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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 has failed to ensure that staff participate in the implementation of the infection prevention and control program.

During medication administration observation it was noted that an identified RPN was administering medication to identified residents without performing hand hygiene. They were seen crushing medication, disposing waste, touching surfaces, administering medication to residents but no hand hygiene was observed in-between.

The RPN was observed administering oral drugs to a resident and subcutaneous injection and puffers to an identified resident with no hand hygiene in between.

In an interview the RPN indicated that they had allergies to the isolgel hand sanitizer and said that they practice hand hygiene prior to administering eye drops however, did not wash hands during this medication administration pass.

The policy called Hand Hygiene section "H" page 12.0 revised March 20, 2016, stated to clean hands immediately before any aseptic procedure e.g. oral dental care, eye drops, giving medication, catheter insertion and changing a dressing. To protect the resident against harmful germs including the residents own germs, entering his or her body.

The DOC acknowledged that the RPN did not follow best practice and effective hand hygiene during medication administration.

The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program. [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 that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

WN #5: 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 has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

It was observed during medication administration that an RPN had left the medication cart unlocked to administer medication to identified residents on three different occasion.

At 1231 hours, the medication cart was moved to the small dining room. It was observed that the medication cart was left unlocked and unattended while the RPN administered drugs to the resident in the small dining room. The cart was not in sight of the RPN.

In an interview RPN indicated that they had "bad habits" when it came locking the medication cart.

The DOC acknowledged that the medication cart was to be locked at all times especially when registered staff was leaving the cart unattended. [s. 129. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Record review showed that an identified resident had an order for a drug with specific instructions.

During medication administration observation it was noted that an identified RPN did not offer the drug to the resident.

The identified RPN indicated that the resident refused the drug and they had tried different interventions in the past but it was also refused by the resident, therefore, the drug was not being offered at this time.

The DOC acknowledged that the drug should have been offered to the resident as per physician's order and if the resident refuses then it was to be documented.

The licensee has failed to ensure that drugs were administered to the identified resident in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 10th day of October, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NUZHAT UDDIN (532)
Inspection No. / No de l'inspection :	2018_601532_0014
Log No. / No de registre :	016626-18, 016630-18
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 6, 2018
Licensee / Titulaire de permis :	LaPointe-Fisher Nursing Home, Limited 1934 Dufferin Avenue, WALLACEBURG, ON, N8A-4M2
LTC Home / Foyer de SLD :	LaPointe-Fisher Nursing Home 271 Metcalfe Street, GUELPH, ON, N1E-4Y8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dahlia Burt-Gerrans

To LaPointe-Fisher Nursing Home, Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_604519_0006, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.
Specifically the licensee must:
a) Ensure that resident #001, and any other resident, is provided with supplements as specified in their plan of care.
b) Ensure that resident #007, and any other resident, receives personal hygiene as specified in their plan of care.
c) Ensure that the Food and Nutrition Manager reviews with the Registered Dietitian, the process for communicating changes related to the provision of nutritional supplements, labelled snacks and diets. This process and the review should be documented.
d) Ensure that the interventions related to falls prevention are provided to resident #017, and any other resident, as specified in their plan of care.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as set out in the plan.

a) Review of identified resident's weights indicated that there was a significant weight change.

The Registered Dietitian (RD) documented in a follow-up assessment that there was a significant weight change in the past month. Strategies were identified to address the weight loss and it included interventions.

An identified Personal Support Worker was observed passing out afternoon

nourishment to residents. Inspector checked the nourishment cart and did not observe the intervention for the identified resident.

Review of identified resident's record indicated that there was no documentation that the resident was to have the intervention.

The FSM acknowledged that the RD had documented in a progress note regarding the identified resident's intervention, however, the FSM missed to update the diet sheets and the care plan to include the intervention.

b) A complaint submitted to the Ministry of Health and Long Term Care (MOHLTC) identified concerns regarding personal care.

Observation showed that personal care was not done and this was confirmed by an identified PSW.

Review of the identified resident's record indicated that they had responsive behaviours related to their diagnosis.

Resident's records stated that personal care was to be checked and completed as needed on a daily basis.

Identified PSWs and RPNs all confirmed in interviews that the specified resident was resistive to having their personal care done.

Interventions were outlined in the care plan when the identified resident refused the personal care and their family was to be contacted to elicit family input for the best approaches to take with the identified resident.

Record review of resident progress notes did not indicate that the resident's SDM / family was notified about the resident's refusal to have personal care done as indicated in the resident's written care plan.

The Administrator stated that the care plan for the identified resident had not been followed with respect to personal care.

c) An identified resident's care plan stated that they were at high risk of falls and further interventions were identified.

The resident was observed lying in bed on three different identified dates and the interventions were not in place and this was acknowledged by a PSW.

DOC acknowledged that the interventions were not in place and the care set out in the plan of care was not provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care for the identified residents was provided to the residents as specified in their plan. [s. 6. (7)]

The severity of this issue was determined to be a level two as there was potential for actual harm to the residents. The scope of the issue was a level one as it related to two out of more than ten residents reviewed. The home had a level five history, multiple non-compliances with at least one related order to the current area of concern.

VPC issued September 24, 2015, inspection #2015_226192_0050
VPC issued September 24, 2015, inspection #2015_226192_0051
VPC issued March 10, 2017, inspection #2017_604519_0004
CO issued May 17, 2017, inspection #2017_604519_0006 (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 19, 2018

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_604519_0006, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 8. (1) of Ontario Regulation 79/10. Specifically the licensee must:

a) Ensure that resident #002 and any other resident of the home with identified altered skin integrity is reassessed at least weekly using the weekly skin and wound assessment as identified in the skin and wound policy.

b) Ensure that the policy related to fall prevention specifically post fall assessment, head injury routine (HIR), when indicated, post fall huddle form is completed for resident #015, #016 and #017 and for any other resident in the home who has fallen.

c) Ensure that the registered staff stay with the resident #005, #006, #019 until medication has been swallowed and initial the medication administration record sheet immediately after administering the medication, as per the home's Administration of Medication-Oral Medication policy.

Grounds / Motifs :

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

In accordance with Ontario/Regulation 79/10, s. 48.(1)(2) the licensee was required to ensure that 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 was developed and implemented.

Specifically, staff did not comply with the licensee's policy regarding "Skin and Wound Care" section S, dated as revised March 4, 2016.

Review of weekly skin assessment showed that the identified resident had altered skin integrity.

Record review showed that there were missing weekly assessments for the identified dates.

Registered Nurse (RN) stated that the RNs were to complete the assessment (initial and weekly), Treatment Administration Record (TAR) review, and communication note for the physician, the care plan, progress notes and update the treatment.

RN acknowledged that there were missing assessments under the assessment tab in PCC and referred the Inspector to Wound Care Champion.

Wound Care Champion (WCC) checked the TAR for documentation for the altered skin integrity and were not able to find the missing weekly wound assessments.

Associate Director of Care (ADOC) acknowledged that the skin assessment was not done on a weekly basis for the identified resident. They indicated that they found that the registered staff were documenting multiple skin and wound issues into one assessment and were not making notes regarding improvement or deterioration. The ADOC reported that the tool that staff were currently using did not indicate if the wound was improving or deteriorating. They said that the assessment was not based on best practice.

The licensee has failed comply with the "Skin and Wound Care" policy specifically weekly skin and wound assessment. (532)

2. In accordance with Ontario Regulation 79/10, s. 49.(1) the licensee was required to ensure that there was a falls prevention and management program

that included strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Specifically, staff did not comply with the home's Falls Prevention and Management policy, "Part B: Post Fall Assessment and Management" effective March 2, 2011, and revised January 30, 2015.

a) Critical Incident Report and record review for an identified resident reported that they had an un-witnessed fall. The resident was taken to hospital where they received interventions.

There was no evidence in the clinical record that a post fall assessment and head injury routine had been completed for the fall. This was verified by an identified RPN.

b) Critical Incident Report and record review for another identified resident reported that they had an un-witnessed fall which resulted in a transfer to hospital for a possible injury and had another un-witnessed fall on an identified date.

During an interview the DOC confirmed that post fall, a post fall huddle form would come to the DOC's office where they were reviewed and recommendations developed. However, DOC stated that they did not have any post fall huddle reports for the identified fall.

DOC stated that there were no head injury routine for the identified resident after their un-witnessed falls.

c) Critical Incident Report and record review for an identified resident reported that resident had an un-witnessed fall which resulted in an injury and transfer to hospital.

DOC stated that they do not have any post fall huddle reports for identified date.

RPN/RAI reported that there were no documents found for a head injury routine assessment or for the post fall huddles for the identified resident after their un-witnessed fall.

The licensee has failed to ensure that the home's Falls Prevention and Management policy was complied with in relation to identified resident's fall. [s. 8. (1) (a),s. 8. (1) (b)] (532)

3. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with Ontario/Regulation 79/10, s. 114. (2) the licensee was required to ensure that written policies and protocols were 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.

Specifically, staff did not comply with the licensee's policy regarding "Administration of Medication- Oral Medication" Section M, Page 2.6, dated as reviewed March 4, 2016.

It was observed that an identified RPN prepared the medication for administration for an identified resident and initialed the medication administration record (MAR) sheet as given before it was offered to the resident.

It was observed that the identified RPN prepared the medication for administration and gave the drug to an identified resident in their hand and walked away. The RPN did not ensure that the resident took the medication. The RPN was observed preparing medication for another resident and did not go back to ensure that the identified resident took the drug. RPN was observed documenting on the medication administration record that the drug was given, however, the resident had not taken the medication until later. The resident was observed holding the medication for few minutes before ingesting it.

The care plan for the identified resident stated, encourage the resident to take medications but did not identify for them to self-administer medication.

It was observed that an identified RPN prepared a drug for another identified resident, and placed it on the table in front of them and walked away. The RPN was observed going back to the cart and initialing the medication administration record sheet as drug was given. However, the resident kept the medication to

the side and did not take the medication right away. The RPN was not observed encouraging the resident to accept staff administering the drug, and were noted that they had moved on to the next resident while the drug was still sitting on the dining table. The identified resident was sharing the table with co-resident.

The plan of care for identified resident stated, encourage the resident to accept staff administering drugs.

An identified RPN acknowledged that they signed for medication prior to administering it as they had worked in the home for a long time and knew the residents. The identified RPN reported that they followed the practice of signing the medication record before administering medication. They explained that if the resident refused they would go back and cross off the medication administration and would make a progress note afterwards.

DOC acknowledged that the practice was to sign after the medication was administered to ensure that residents took the medication and staff were to stay with the resident until medication was swallowed.

The licensee has failed to ensure that policy regarding "Administration of Medication- Oral Medication" was complied with. [s. 8. (1) (b)]

VPC issued April 13, 2016, inspection #2016-448155-0004
CO issued May 17, 2017, inspection #2017_604519_0006
VPC issued January 25, 2018, inspection #2017_660218_0013
VPC issued June 26, 2018, inspection #2018_723606_0007 (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 19, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 6th day of September, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Nuzhat Uddin

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