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 # / Registre no	Type of Inspection / Genre d'inspection
Apr 25, 2017	2017_556168_0010	006881-17	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Fox Ridge Care Community
389 WEST STREET BRANTFORD ON N3R 3V9

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

LISA VINK (168), DIANNE BARSEVICH (581), JESSICA PALADINO (586), MELODY GRAY (123)

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): April 4, 5, 7, 10, 11, 12 and 13, 2017.

Inspector Lisa Bos, inspector number 683, participated in this inspection.

During the course of this inspection the following inspections were completed concurrently.

Follow Up inspection
Log number 013305-16, from inspection number 2016-337581-0003 for Ontario Regulation 79/10 section 8(1)b.

Complaints
Log number 015596-16, for Infoline number IL-44664-HA related to coercion prohibited, responsive behaviours and prevention of abuse and neglect.
Log number 023348-16, for Infoline number IL-45976-HA related to Residents' Bill of Rights, bathing, continence care and bowel management and prevention of abuse and neglect.
Log number 030485-16, for Infoline number IL-47460-HA related to falls prevention and management and plan of care.
Log number 030656-16, for Infoline number Il-47494-HA related to falls prevention and management.

Critical Incidents
Log number 024380-16, for Critical Incident number 2570-000007-16 related to prevention of abuse and neglect.
Log number 000621-17, for Critical Incident number 2570-000002-17 related to duty to protect.
Log number 025957-16, for Critical Incident number 2570-000010-16 related to medication incidents and adverse drug reactions and administration of drugs.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Co-ordinator, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), environmental staff, Environmental Services Supervisor (ESS), Director of Resident and Family Relations, housekeeping staff, Behavioural Supports Ontario (BSO) staff, Food Services Manager (FSM), Office Manager, Scheduling Coordinator, family members and residents.

During the course of this inspection, the inspectors: observed the provision of care and services, toured the home, reviewed records including but not limited to: meeting minutes, training records, policies and procedures and clinical health records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **10 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
O.Reg 79/10 s. 8. (1)	CO #001	2016_337581_0003	168

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for the residents.

On two identified dates in April 2017, resident #031's room contained three large bottles of vitamins and one box of an identified over the counter medication, accessible and located on the bedside table.
The ADOC acknowledged that residents were not permitted to maintain vitamins/medication on their bedside tables and that all medications were to be maintained in a secured area, to be administered by registered nursing staff.
It was identified that currently the home did not have any residents who had a physician's orders in place to self administer medications.
The vitamins/medications were removed by the ADOC on the second day, when the issue was identified to them by the Inspector.
The ADOC confirmed that they, nor the RPN on duty were aware that the vitamins/medications were accessible in the resident's room and that they were not provided to the resident by the home.

The home was not a safe and secure environment for resident.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for the residents, to be implemented voluntarily.

WN #2: 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. (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).

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A review of the clinical record identified that resident #022 had a history of falls with injuries.
Physiotherapy assessments and diagnostic reports identified that on an identified date in September 2016 and a second date in November 2016, the resident fell and sustained multiple injuries as a result of these incidents.
A review of the Minimum Data Set (MDS) assessment completed in December 2016, identified that the resident fell in the past 31 to 180 days; however, did not identify they

had sustained the identified injury in the last 180 days.
A review of the MDS assessment completed in March 2017, did not identify that the resident fell in the past 31 to 180 days nor the identified injury in the last 180 days.
Interview with RPN #100 confirmed that MDS assessments, Physiotherapy assessments and diagnostic reports were not consistent with each other as the resident did fall and sustained multiple injuries during the identified time period.

Staff and others involved in the different aspects of care of the resident did not collaborate with each other in the assessment of the resident so that their assessments were integrated, were consistent with and complemented each other.

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

A. Resident #022 was observed on three dates in April 2017, without devices in place.
On a date in April 2017, it was communicated to the Inspector that the resident was to have the devices applied at a specific time only, for protection, but that the staff did not provide this care.
The plan of care was reviewed and identified that resident's devices were to be applied on all three shifts, a different period of time than previously reported.
A review of a progress note created in December 2016, identified that the devices were to be applied as communicated in April 2017, during the specified time only.
Interview with PSW #145 stated that the resident did have the devices; however, they were not used.
PSW #143 acknowledged that they were unaware the resident had the devices or that they were to be used.
RPN #128 confirmed that PSW staff did not apply the devices as specified in the plan of care.
B. On a specified date in April 2017, resident #022 was observed positioned in their wheelchair without a PASD in use.
Review of the plan of care identified that they required the personal assistance service device (PASD).
PSW #143 stated the resident did not require the device to be applied and had not been applying it on their shift.
RPN #128 confirmed that the application of the device was planned care for the resident and should have been applied.

Care was not provided as set out in the plan of care. [s. 6. (7)]

3. The licensee failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

A. On a specified date in April 2017, resident #022 was observed in their wheelchair with no PASD in use.
PSW #143, who was a primary care giver for the resident, stated that the resident did not use a PASD when up in their wheelchair.
The Kardex and Point of Care (POC) documents were reviewed with the PSW.
These documents indicated direction for use of the device and that it was to be applied when up in the chair as a PASD.
The PSW was not aware of the contents of the resident's plan of care related to the use of the device.
B. Review of the written plan of care and Kardex for resident #022 indicated that staff were to apply devices on all three shifts and monitor.
PSW #143, who was the primary care giver for the resident, stated that they did not apply the devices, were not aware of where there were kept in the resident's room and confirmed that they were unaware that the application of the devices was documented in the resident's plan of care.
RPN #128 verified that they were not aware of the resident's need for the devices and felt that they were discontinued some time ago.
The Inspector reviewed the plan of care with the RPN who confirmed direction for use of the devices was in the plan; however, they verbalized that they had just reviewed the need for devices with the ADOC who also believed that they were not a current need, were discontinued and not part of the plan of care.
PSW #145 identified that according to their knowledge, based on a statement made by the family, the resident was only to use the devices during a specified time period; however, they were not aware of the directions for use as recorded in the plan of care.

Staff who provided direct care to a resident were not kept aware of the contents of the resident's plan of care. [s. 6. (8)]

4. The licensee failed to ensure the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A. The plan of care for resident #020 identified they had a PASD.

PSW #102 stated that the device was not applied when the resident was in the wheelchair, which was confirmed with the resident.
RPN #100 confirmed that the plan of care was not reviewed and revised when the use of the PASD was discontinued.
B. Resident #022 was observed on three dates in April 2017 and did not have devices in place.
Review of the written plan of care, including the Kardex identified that the resident was use the devices on all three shifts.
PSW #145 identified that the resident had not used the devices for several months and thought that they were only to be used at a specified period of time; however, based on the condition that they found the resident in, when the provided care at the beginning of their shift the devices were not used.
Progress notes included an entry in December 2016, where the resident's family reported that an external consultant recommended the use of the devices during a specified period of time for protection.
RPN #128 confirmed that the devices were to be used during the specified period of time, according to the progress note and that the plan of care was not reviewed and revised related to changes in care needs.

The residents were not reassessed and the plans of care reviewed and revised at least every six months and at any other time when the resident’s care needs changed or care set out in the plan was no longer necessary. [s. 6. (10) (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 that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and consistent with and complement each other, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to ensure that staff and others who provided direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it and to ensure the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and their bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident and to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident #030 was observed with a bed rail in the raised position on their bed on two dates in April 2017.
The resident was interviewed and indicated that their were not provided the rail by the home.
Interview with the ADOC identified that they were previously unaware of the use of the rail.
When requested, the home was not able to provide documentation of an assessment of the resident or an evaluation of the bed system, which confirmed by the ADOC.
An assessment was completed of the resident and their bed system was evaluated on a specified date in April 2017, as required.
Environmental staff #110 confirmed that the rail was not provided by the home and that steps were not taken to prevent entrapment, taking into consideration all potential zones of entrapment, which was supported by the ADOC.
The bed rail was removed from the resident's bed and was replaced by the home the same day with a suitable rail, which minimized risk to the resident.

The licensee did not ensure that where bed rails were used, the resident was assessed and their bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident nor were steps taken to prevent resident entrapment. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, the resident is assessed and their bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #4: 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 were kept clean and sanitary.

On April 4, 2017, a spa area was noted to contain a shower chair which was soiled with long white stains and a large yellow stains on the shower drain.
PSW #125 identified that the spa room was not used very often; however, confirmed that the room was not ready for use and was not clean.
PSW #126 stated that they used this shower occasionally, for one identified resident and confirmed that room was not clean and should have been.
RPN #100 confirmed that the enclosed shower and chair were soiled and that the home did not ensure that the area and equipment were clean and ready to be used by

residents.

The home, furnishings and equipment were not kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee failed to ensure that the home was maintained in a safe condition and in a good state of repair.

During a tour of a home area it was identified that the flooring in the spa room and an identified bathroom was not in a good state of repair.
A. The spa flooring had a crack at the seam which measured approximately 29 centimeters (cm) long by 2 cm wide, near the tub fixture, which was no longer sealed with caulking and had an irregular shaped hole in the flooring, near the seam, which measured approximately 8 cm long by 3 cm wide at the largest part.
Flooring in the shower area, near the drain had lifted which resulted in the accumulation of water under the flooring material, as well as a crack which measured approximately 14 cm long.
The flooring material, at the entrance of the shower area, had an irregular shaped hole which measured approximately 29 cm long by 12 cm wide at the largest part.
Interview with PSW #106 identified concerns with the spa flooring which made it difficult for staff to push a mechanical lift or shower chair over the areas.
Interview with the ESS shared plans to replace the flooring in the spa area by the end of June, 2017, which was confirmed by the Administrator.
B. The flooring in the identified bathroom had a crack and chipping away of flooring material which was irregular in shape and measured approximately 15 cm by 5 cm, at the widest part.
Interview with the ESS shared plans to replace this floor, as well as three other resident washrooms, in need of replacement, by August 2017, which was confirmed by the Administrator.

The home, specifically flooring, was not maintained in a safe condition and in a good state of repair. [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 that the home, furnishings and equipment are kept clean and sanitary and that the home is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident was protected from abuse.

Resident #040 had a history of responsive behaviours towards residents and staff. The resident had a plan of care in place related to the management of behaviours and had specialized external resources who had assessed them and/or were part of their interdisciplinary care team.
i. On a specified date in May 2016, the resident demonstrated responsive behaviours towards resident #042.
ii. On a specified date in July 2016 and a separate date in August 2016, the resident demonstrated responsive behaviours towards resident #043.
iii. On another date in August 2016, the resident demonstrated responsive behaviours towards resident #041, which resulted in an area of altered skin integrity and reported pain.
Documentation and interview with the DOC on April 10, 2017, confirmed that resident #041 was upset by the incident which involved co-resident #040.
Resident #042 witnessed the incident in August 2016, and when interviewed, acknowledged resident #041's response to the incident and that they were upset.

Resident #041 was not protected from abuse by resident #040. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident is protected from abuse, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the method of their choice, including tub baths, showers, and full body sponge baths, unless contraindicated by a medical condition.

A. Review of resident #020's POC bathing records from January 2017, until April 9, 2017, identified that there were six occasions when they received a bed bath, during the identified period of time.
Interview with the resident identified that a shower was their preferred method of bathing; however, when the home did not work with their desired staffing compliment, they received a bed bath rather than a shower at the request of the staff.
B. Review of resident #051's POC bathing records from January 2017, until April 7, 2017, identified that there were four occasions when they received a bed bath and six occasions where the resident was identified as "not applicable" for bathing, during the identified period of time.
Interview with the resident identified that a shower was their preferred method of bathing and that they, in their opinion, were not consistently bathed two times per week, like other residents of the home.

PSWs #125, #126, #131, #132, #134, #135, #136 and RPN #100 each acknowledged that when the home was not able to work with the desired compliment of PSW staff, according to the staffing plan, PSWs were redirected from an identified home area to the area of the home with the vacant shift.
This reassignment of staff, at times, resulted in residents on the identified home area, not being bathed according to their plans of care, for example a bed bath would be provided rather than a tub or shower or staff not would not complete the task of bathing due to lack of available resources.
PSW staff interviewed identified that they would record "not applicable" in the effected residents POC records when they were not able to complete any bathing activity as per the bathing schedule.
Interview with the ADOC and Administrator communicated strategies currently in place in an attempt to "make up" missed bathing, to fill vacant shifts and vacant positions to reduce working below the desired staffing compliment.

Not all residents were bathed, at a minimum, twice a week by the method of their choice, unless contraindicated by a medical condition. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is bathed, at a minimum, twice a week by the method of their choice, including tub baths, showers, and full body sponge baths, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD used under section 33 of the Act, was applied by staff in accordance with any manufacturer's instructions.

On a specified date in April 2017, resident #022 was observed seated in a wheelchair with a PSAD which was not applied according to manufacture's instructions.
Interview and observation of the PASD with RPN #123 verified that the device was not applied correctly according to the manufacturer's instructions and the staff member proceeded adjusted the PASD as appropriate.

The PASD was not applied in accordance with manufacturer's instructions. [s. 111. (2) (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 that a PASD used under section 33 of the Act, is applied by staff in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #8: 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 failed to ensure that drugs were administered to residents in accordance with the directions for use as specified by the prescriber.

According to the clinical record and an incident report, resident #032 had a physician's order for an analgesic to be administered at a specified frequency, after the previous dosage was removed.
On an identified date in August 2016, staff identified that the resident had received more medication, than the prescribed dosage.
It was verified by the home that registered nursing staff administered another dosage of the medication, when the error was identified.
During this time the resident demonstrated a change in status, the physician was notified, orders were received, they were monitored and transferred to hospital.
Interview with the ADOC, verified the information as recorded in the clinical record and incident report and confirmed that staff did not administer the medication as ordered.

The drug was not administered to the resident as specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident which involved a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's Substitute Decision Maker (SDM), the DOC, the Medical Director,

the prescriber of the drug, the attending physician or the registered nurse in the extended class and the pharmacy service provider.

The home's Medication Incidents Reports and Medication Incident Report Tracking tool from January to April 2017, were reviewed.
This review identified that the immediate actions taken to assess and maintain the residents' health was not consistently documented.
There was no documentation available to indicate that a number of medication incidents were reported to the residents, the SDMs, the prescriber, the attending physician or the registered nurse in the extended class or the pharmacy service provider.
The documentation did not consistently include that all required individuals were notified of the incidents.
Interview with the ADOC identified that there were unable to provide additional information regarding the incidents other than what was recorded in the incident reports and confirmed that the actions taken were not consistently documented nor that the required individuals were notified of the incidents.

Not every medication incident which involved a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, the DOC, the Medical Director, the prescriber of the drug, the attending physician or the registered nurse in the extended class and the pharmacy service provider. [s. 135. (1)]

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

The home's medication incidents from January 2017 to April 2017, were reviewed.
A review of the records identified that documentation did not consistently include that all medication incidents were reviewed and analyzed, nor corrective action was taken as necessary.
Interview with the ADOC confirmed that the records did not include that all medication incidents were reviewed, analyzed or action taken was documented as required.

Documentation did not support that all medication incidents and adverse drug reactions were reviewed and analyzed, nor corrective action taken as necessary. [s. 135. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident which involved a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and is reported to the resident, the resident's Substitute Decision Maker (SDM), the DOC, the Medical Director, the prescriber of the drug, the attending physician or the registered nurse in the extended class and the pharmacy service provider and that all medication incidents and adverse drug reactions are documented, reviewed and analyzed, and corrective action is taken as necessary, and a written record kept of everything required, to be implemented voluntarily.

WN #10: 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 participated in the implementation of the infection prevention and control program.

The home's policy, Hand Hygiene, number IX-G-10.10, last revised April 2016, identified that all team members were expected to practice hand hygiene, including hand washing or alcohol-based hand rub, after contact with body substances or specimens, contaminated or soiled items (laundry, waste, equipment).
A. On April 4, 2017, the noon meal was observed.
PSW #124 was observed to feed two residents and then clear their empty dishes from the table.
The PSW proceeded to serve other residents their meal before they returned to assist the initial two residents with feeding assistance.
The PSW did not complete hand hygiene from the time that they cleared the soiled dishes, served additional plates and then assisted residents with their meal.
Interview with the DOC on April 4, 2017, confirmed that staff were expected to sanitize their hands between clearing dishes and feeding residents.
B. On April 11, 2017, the noon meal was observed.
PSW #124 was observed to feed a resident and clear their dirty dishes.
The PSW then proceeded to cue a second resident to eat by handing them their spoon, held a cup to feed a third resident and then returned to the first resident to feed dessert, all without hand hygiene.
On April 11, 2017, the FSM confirmed the expectation was for all staff to sanitize their hands between dirty and clean dishes and with resident contact, which included either hand washing or the use of alcohol-based hand rub.

The home's infection prevention and control program related to hand hygiene was not followed. [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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: 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 failed to ensure the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's had a policy, Prevention of Abuse & Neglect of a Resident, policy number VII-G-10.00, last revised January 2015.
This policy directed all employees to immediately report any suspected or known incident of abuse or neglect to the Director.
On an identified date in August 2016, at 1400 hours, resident #040 abused resident #041.
The incident was not reported to the Director for 24 hours, until the following day at 1459 hours.
Interview with the ADOC acknowledged that the Director was not immediately informed of the incident of abuse as required.

The written policy to promote zero tolerance of abuse and neglect of residents was not complied with. [s. 20. (1)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

On two dates in April 2017, resident #020 was observed positioned in their wheelchair with a device in place.
The resident and PSW #102 were interviewed and identified that the device was applied by PSW staff when the resident was positioned into their wheelchair and removed when the resident was not in the chair.
The interviews identified the purpose of the device and that the resident was unable to apply or remove the device.
A review of the clinical health record did not include the application of the device in the plan of care nor was there an assessment of the device, as confirmed with RPN #100.

The PASD described in subsection (1) was used to assist a resident with a routine activity of living without the use of the device being included in the resident's plan of care. [s. 33. (3)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee failed comply with the conditions to which the licence was subject.

The Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system, which required each resident's care and service needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the assessment reference date (ARD) of the previous assessment, and any significant change in resident's condition, to be reassessed along with resident assessment protocols (RAPs) by the interdisciplinary care team using the MDS Full assessment by the 14th day following the determination that a significant change in status had occurred.
The licensee did not comply with the conditions to which the license was subject for the resident #022.
A review of the clinical record, for the September, 2016, MDS RAI did not include a triggered RAP for falls, despite coding for falls, which the resident sustained in the past 30 days, as confirmed by the RAI Co-ordinator.
The RAI Co-ordinator identified that the home documented their RAPs as an Interdisciplinary Care Conference and that the nursing summary, which would be used in place of a RAP, was not completed for this triggered issue.

The licensee did not comply with the conditions to which they were subject to. [s. 101. (4)]

Issued on this 1st day of May, 2017

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

Original report signed by the inspector.