Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 20, 2019	2019_556168_0014	032837-18, 032840-18, 032841-18, 032842-18, 003096-19, 009110-19, 009111-19	Follow up

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM 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), DARIA TRZOS (561), DIANNE BARSEVICH (581)

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): August 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, 2019 and September 3 and 4, 2019.

Please note that the following Follow Up Inspections were completed during this inspection:
Log number 032837-18 for Ontario Regulation (O. Reg.) 79/10 section (s.) 50(2),

related to skin and wound care;
Log number 032840-18 for O. Reg. 79/10 s. 31(3), related to nursing and personal support services;
Log number 032841-18 for O. Reg. 79/10 s. 33, related to bathing;
Log number 032842-18 for O. Reg. 79/10 s. 52(2), related to pain management;
Log number 003096-19 for O. Reg. 79/10 s. 36, related to transferring and positioning techniques;
Log number 009110-19 for Long Term Care Homes Act (LTCHA) s. 6(7) related to plan of care; and
Log number 009111-19 for LTCHA s. 8(3) related to nursing and personal support services.

Please note that the following inspections were completed concurrently with this Follow Up inspection:
Complaint Inspection, Inspection number 2019_556168_0012; and
Critical Incident System Inspection, Inspection number 2019_556168_0013.

A Voluntary Plan of Correction (VPC) related to O. Reg 79/10 s. 8(1)(b) identified in concurrent inspection #2019_556168_0013, was issued in this report.

A VPC related to O. Reg 79/10 s. 30(2) was identified in this inspection and has been issued in Inspection Report #2019_556168_0012, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the acting Director of Care (aDOC), the Assistant Director of Care (ADOC), the Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Clinical Care Partner, housekeeping staff, the Director of Dietary Services, a Care Support Assistant (CSA), family members and residents.

During the course of the inspection, the inspector(s) observed the provision of care and services, reviewed documents including but not limited to: audits, schedules, plans, clinical health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Pain
Personal Support Services
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 31. (3)	CO #006	2018_570528_0002	168
O.Reg 79/10 s. 33.	CO #005	2018_570528_0002	168
O.Reg 79/10 s. 36.	CO #001	2018_543561_0016	581
O.Reg 79/10 s. 50. (2)	CO #001	2018_570528_0002	168
O.Reg 79/10 s. 52. (2)	CO #004	2018_570528_0002	168
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2019_695156_0001	168
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #002	2019_695156_0001	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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to ensure protocols included in the required Skin and Wound Care program were complied with.

In accordance with O. Reg. 79/10, s. 48(1)2, the licensee was required to have an interdisciplinary Skin and Wound Care program.
Specifically, the licensee failed to comply with their Skin and Wound Care Management Protocol, VII-G-10.90, revision April 2019, which identified that "with a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds", the nurse will "update the plan of care, including the Treatment Administration Record and care plan as appropriate".

Resident #020, was identified, according to their Skin and Wound Assessment – V2, on an identified date in August 2019, with two new areas of altered skin integrity, as documented by RPN #138. The assessment identified that a specified treatment was applied to the areas.
On an identified date in August 2019, RPN #120 reassessed the areas and noted that one of the areas had healed over with a scab present.
A review of the August 2019, electronic Treatment Administration Record (eTAR) did not include one of the areas of altered skin integrity, as confirmed during a record review with RN #109 and RPN #120.
RN #109 and RPN #120 confirmed the expectation, that as per the Skin and Wound Care Management Protocol, treatments be included on the eTAR.

The protocol was not complied with. [s. 8. (1) (b)]

2. The licensee failed to ensure policies included in the required Medication Management

System were complied with.

In accordance with O. Reg. 79/10, s. 114(2) the licensee was required to have written policies and protocols 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.

1. Specifically, the licensee failed to comply with their policy Combined Individual Monitored Medication Record with Shift Count, by Medical Pharmacies, number 6-7, revised November 2018.
This policy directed "at shift change, two registered staff (ongoing and incoming) together: count the actual quantity of medications remaining; confirm actual quantity is the same as the amount recorded on the entry of quantity/balance and record the date time, quantity of medication and sign".

A. Review of the Emergency Box Narcotic - Shift Change Monitored Medication Count sheets identified the following.
i. For the records from an identified date in April 2019, until an identified date in May 2019, the sheets included two blank spaces for the nurses signature, on an identified date in May 2019, as well as four downward arrows, from and identified date in April 2019, until another identified date in May 2019, which suggested that staff signed their signature in the incorrect box.
ii. For the records from an identified date in July 2019, until an identified date in August 2019, the document included a total of seven blank spaces for the nurses signatures. The document also included six downward arrows, from an identified date in July 2019, until another identified date in July 2019, which suggested that staff signed their signature in the incorrect box.
The acting DOC reviewed the documents and confirmed that the policy was not complied with for the identified examples.

B. A review of an identified home area's Shift Change Monitored Medication Count sheets, which were signed as reviewed/audited on an identified date in May 2019, identified that the count for a specified medication, prescribed for resident #023, was changed from the number "2" to the number "1" on eight occasions. There was no documentation on the record regarding who made the changes or when they were made.

The acting DOC reviewed the documents and confirmed that the policy was not complied with for the identified examples.

C. The Shift Change Monitored Medication Count sheets for and identified date in August 2019, were reviewed prior to evening shift change scheduled for 1500 hours and the following were noted:
i. At 1311 hours, the Count Sheets for two identified home areas did not have the "starting nurse" signature for 0700 hours, for any of the medications. RPN #110 confirmed that they had completed the count, at 0700 hours, with the "leaving nurse"; however, in error failed to sign the document. The records were immediately signed.
ii. At 1359 hours, the Count Sheets for an identified home area had the "total quantity remaining" column completed, with the number of medications which remained, for 21 of 24 resident medications, for 1500 hours; however, there were no signatures documented for the numbers recorded.
iii. At 1359 hours, the Count Sheets for two identified home areas had the "total quantity remaining" column completed, for 1500 hours, with the number of medications which remained for all resident medications and was signed by RPN #103 as the "nurse leaving". There was no signature for the "nurse starting" the shift.
The records were shown to the Clinical Care Partner prior to shift change, who confirmed that the records were not completed as per the expectation and communicated education was currently in place to reinforce the policy requirements with registered staff.

2. The licensee failed to ensure policies included in the required Medication Management System were complied with.

Specifically, the licensee failed to comply with their policy, Drug Destruction and Disposal, by Medical Pharmacies, number 5-4, revised February 2017.
This policy directed "all medications which become surplus due to expiry, illegible labels, discontinuation, change in order, resident death or discharge, containers not meeting requirements of legislation are destroyed and disposed of, according to applicable legislation" and identified that for monitored medication "the Drug Destruction and Disposal list shall include documentation of:
a. date of removal of the drug from the drug storage area,
b. name of the resident,
c. prescription number,
d. drug name, strength and quantity,
e. reason for destruction,
f. date drug was destroyed,
g. names of members of destruction team,
h. manner of destruction of the drug,

i. document a. to e. when removing drug from active orders in cart,
j. document f. to h. when drug destroyed by team".

O. Reg 79/10 s. 136(4) detailed documentation expectations for the destruction and disposal of controlled substances.

A. An email from RN #109, to the former DOC, on an identified date in April 2018, identified specific concerns with the storage of controlled substances in the home, specifically: for resident #022 and the location of another identified controlled substance, which was unknown if it was prescribed for a resident.
During an interview, RN #109 identified that they did not administer these medications, placed them in a plastic baggie, into the locked narcotic bin in their medication cart for the former DOC to observed and take action(s) as appropriate. On their return to work, several shifts later, RN #109 noted that the identified medications were no longer in the narcotic bin and they assumed that they had been removed/destroyed by the former DOC.
Interview with the former DOC identified that they had no recall of the email, the identified medications, nor were they able to recall any actions taken as a result, including destruction.
Interview with the pharmacist confirmed that a number of controlled substances in a baggie to be destroyed would be something that they would "question"; however, they had no recall of such a situation in the home.
A review of the Drug Destruction and Disposal Monitored Substances records, which were utilized on and around April 2018, which were signed as destroyed by the pharmacist and ADOC, on an identified date in May 2018, did not include any documentation related to the identified medications.
An email, to the Inspector, from the acting DOC, on behalf the ADOC and themselves, confirmed that the identified medications were not listed on the Drug Destruction and Disposal Monitored Substances records provided, that they were not able to confirm how the medications were destructed and that they did not have any further details regarding the identified medications.

The policy was not complied with.

Please note that this non compliance was identified during Critical Incident System Log number 014645-19. [s. 8. (1) (b)]

3. The licensee failed to ensure that policies which supported their required Falls

Prevention and Management Program were complied with.

In accordance with O. Reg. 79/10, s. 48(1)1 the licensee was required to have an interdisciplinary Falls Prevention and Management program.
Specifically, the licensee failed to comply with their policy, Safe Resident Handling, policy number, VII-G-20.30, revised April 2019.
The policy identified that safe resident handling procedures would be promoted to minimize the risk of injury to care team members and ensure the safety of all residents, consistent with the Zero Lift policy. The policy directed that PSW staff would "lift/transfer residents, according to the plan of care/logo card and use transfer and repositioning aids according to the plan of care and all team members would adhere to protocols established in the Occupational Health and Safety Manual for resident transfers and lifts".

In an interview with the Clinical Care Partner they stated education was provided to staff on the Safe Resident Handling Policy at the same time as the Falls Prevention and Management program to support the program.
A review of the plan of care for resident #027 identified they were to be transferred with a device.
A review of the licensee's audit for Safe Lift and Transfers completed, on an identified date in July 2019 and documented on the Supervisor Feedback Form identified that PSW #123 and #124 completed an unsafe lift and an investigation was ongoing.
During an interview with the Director of Dietary Service, they stated that during the completion of the Safe Lift and Transfer audit, it was identified that PSW #123 and #124 admitted that they did not transfer resident #027 with the device, that they conducted the transfer with a different level of assistance.. The transfer, in question, was not witnessed during the auditing process.
Interviews with PSW #123 and PSW #124, acknowledged that, on the identified date, they did not follow the plan of care or the transfer logo posted at the resident's bedside when they transferred the resident.
Interview with the ED, confirmed that, based on the statements of PSW #123 and #124, they performed an improper transfer on the resident and they did not comply with the policy.
The resident was not harmed during the transfer.

The policy was not complied with. [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 that where the regulation required the licensee to put in place any protocol or policy that the protocol and policy is complied with, to be implemented voluntarily.

WN #2: 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. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee failed to comply with the following requirement of the LTCHA, it is a condition of every licence that the licensee shall comply with every order made under this Act.

1. On June 4, 2019, the following compliance order (CO) #002, from inspection number 2019_695156_0001(A1) made under LTCHA s. 8(3) was issued:
The licensee must be compliant with s. 8(3) of the LTCHA, 2007.
1. Specifically, the licensee must ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.
2. To achieve this requirement, the licensee shall develop and implement written strategies in an effort to ensure coverage of vacation relief and sick or absent calls for regular RNs.
The compliance date was June 17, 2019.

The licensee completed step #1 in CO #002.

The licensee failed to complete step #2 in CO #002.
To achieve this requirement, the licensee shall develop and implement written strategies in an effort to ensure coverage of vacation relief and sick or absent calls for regular RNs.

Interview with the acting DOC and the ED confirmed that the home had developed and implemented strategies in an effort to ensure coverage of vacation relief and sick or absent calls for regular RNs; however, these strategies were not documented and available for reference for staff, if needed to replace RN staff for sick or absent calls.
On an identified date in August 2019, the acting DOC provided the Inspector with a revised Registered Staff Contingency Plan which included the written strategies in an effort to ensure coverage of vacation relief and sick or absent calls for regular RNs.

2. On June 27, 2019, the following compliance order, CO #005, from inspection number 2018_570528_0002(A4) made under O. Reg. 79/10 s. 33 was issued:

The licensee must be compliant with s. 33 of O. Reg. 79/10.
Specifically, the licensee must:
1. Ensure all residents, including residents #037, #038, and #009 are bathed twice a week, according to their preference.
2. Develop a written contingency plan for every shift to outline how staff are to ensure baths are made up either through the day or later in the week and post the plan in each home area.
3. Complete an audit of scheduled baths, at an interval of the home's choice, to monitor whether the task is being completed.
4. Keep a documented record of audits completed.
The compliance due date was June 3, 2019.

The licensee completed steps #1, #3 and #4, in CO #005.

The licensee failed to complete step #2, in CO #005.
Develop a written contingency plan for every shift to outline how staff are to ensure baths are made up either through the day or later in the week and post the plan in each home area.

Interview with the acting DOC and the ED confirmed that the home had developed a contingency plan for every shift to outline how staff were to ensure baths were made up either through the day or later in the week; however, the specifics of the plan were not

documented.
Interview with the ADOC and PSW staff #105 and #107 confirmed awareness of the contingency plan to ensure that baths were made up.
A review of an identified home area did not include any contingency plan, which was confirmed with RPN #108.
On an identified date in August 2019, the acting DOC provided the Inspector with a revised written contingency plan which included the plan for every shift to outline how staff were to ensure baths were made up either through the day or later in the week, which was posted in each home area.

3. On June 27, 2019, the following compliance order, CO #006, from inspection number 2018_570528_0002(A4) made under O. Reg. 79/10 s. 31(3) was issued:

The licensee must be compliant with s. 31(3) of O. Reg. 79/10.
Specifically, the licensee must:
The licensee shall prepare, submit and implement a plan to ensure the plan provides for a staffing mix that is consistent with residents' assessed care and safety needs.
The plan must include, but is not limited, to the following:
1. steps that will be taken to ensure that the home is staffed at the assessed staffing complement needs for personal support workers and registered nurses;
2. how the home will ensure the residents' are bathed at a minimum of two days a week;
3. how the home will ensure that they meet the requirement of the Act for 24-hour nursing care; and
4. recruitment and retention of staff.
The compliance date was June 3, 2019.

The licensee submitted a plan to the Ministry, as required, which included:
Immediate Actions:
1. Overtime offered to PSWs and Registered staff. Staffing as per schedule with call ins including overtime as per contingency plan.
2. Conduct an audit to make sure that all residents have a bath/shower scheduled on their plan of care at least twice weekly (as per residents' preference). Bathing report from Point of Care (POC) printed and reviewed weekly. Will offer alternative times for residents to receive a bath/bed bath. Contingency plan to include how to adjust the plan to ensure that bathing is completed as per LTCHA.
3. Continue to post vacant PSW and Registered staff lines internally and externally.
Long Term Actions:
1. Review staffing plan/schedule for both PSWs and Registered nurses. Review and

revise (if necessary) nursing staffing contingency plan to ensure that there are provisions for 24-hr nursing care and there is a process in place to replace staff absences and re-distribute the provision of care.
2. Provide PSW education on provision and documentation of baths.
3. Job Fair will be held twice in 2019 for recruitment of nursing staff. Three days minimum of orientation will be given to all new on-boarded PSWs and five days minimum of orientation will be given to all new on-boarded Registered staff.

The licensee completed Immediate Actions, steps #2 and #3, and Long Term Actions, steps #1, #2 and #3, of their compliance plan, for CO #006.

The licensee failed to complete Immediate Action, step #1 of their compliance plan for CO #006.
Overtime offered to PSWs and Registered staff. Staffing as per schedule with call ins including overtime as per contingency plan.

Interviews with the acting DOC, ED and RNs #109 and #114 each confirmed the use of overtime to replace staffing vacancies.
Records provided demonstrated that overtime was utilized to replace vacant shifts since June 3, 2019.
The home provided training to registered nursing staff regarding the procedure to be followed when they needed to replace a shift. This training included a quiz which noted that overtime would be used when approved by a manager.
A review of the contingency plan, provided on an identified date in August 2019, which was confirmed, by the acting DOC, to be the current plan, did not include the use of overtime or provide direction to staff when to utilize overtime.
On an identified date in August 2019, the acting DOC provided the Inspector with a revised written contingency plan which included the use of overtime and the process to be followed when overtime was to be used, which did not require manager approval.

4. On June 27, 2019, the following compliance order, CO #004, from inspection number 2018_570528_0002(A4) made under O. Reg. 79/10 s. 52(2) was issued:

The licensee must be compliant with s. 52(2) of O. Reg. 79/10.
1. Specifically, the licensee must ensure that when a resident's pain, including but not limited to, resident #020, is not relieved by initial interventions, the resident(s) is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

2. In addition, the home shall review and revise the the Pain and Symptom Management Policy to include clear directions to staff in relation to which pain assessment tools are to be used by staff when residents are experiencing pain and these changes are to be documented.
3. Lastly, the home shall conduct audits, at the schedule of their choosing, to ensure that registered staff are assessing and treating resident's pain as outlined in the Pain and Symptom Management Policy.
The compliance due date was June 17, 2019.

The licensee completed steps #1 and #3, in CO #004.

The licensee failed to complete step #2, in CO #004.
In addition, the home shall review and revise the Pain and Symptom Management Policy to include clear directions to staff in relation to which pain assessment tools are to be used by staff when residents are experiencing pain and these changes are to be documented.

The home provided a copy of the Pain and Symptom Management, policy VII-G-30.10, versions October 2018 and April 2019.
The policy, dated April 2019, was noted to be the current policy in the home and was revised following CO #004.
A comparison of the two versions of the policy identified that the revisions made were specific to the titles of staff and not related to clear directions in relation to which pain assessment tools were to be used by staff when residents experienced pain.
Interview with the Clinical Care Partner, identified that in their opinion the policy, previously and currently, provided clear direction to staff in relation to which pain assessment tools were to be used by staff when residents experienced pain; however, also confirmed that the policy revisions made following the CO were related to the titles of staff and that no other changes were made, including additional directions to staff.
Interview with the RAI Coordinator identified that, since CO #004, the licensee changed the pain assessment tools used by staff when a resident was to be screened for pain as outlined in their policy.

The condition of every licence that the licensee shall comply with every order made under this Act, was not complied with. [s. 101. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee complies with the requirement of the LTCHA including it is a condition of every licence that the licensee shall comply with every order made under this Act, to be implemented voluntarily.

Issued on this 25th day of September, 2019

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

Original report signed by the inspector.