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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Oct 20, 2017	2017_607523_0017	014780-17	Resident Quality Inspection

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

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

Secord Trails Care Community
263 WONHAM STREET SOUTH INGERSOLL ON N5C 3P6

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

ALI NASSER (523), CAROLEE MILLINER (144), INA REYNOLDS (524)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 18, 19, 20, 21, 24, 25 and 26, 2017.

The following inspections were completed concurrently during the RQI:

Critical Incident Log # 016459-17 related to allegations of staff to resident neglect.
Critical Incident Log # 029674-16 related to a resident's fall.
Critical Incident Log # 026857-16 related to alleged resident to resident physical abuse.
Critical Incident Log # 031969-16 related to allegations of staff to resident abuse.
Critical Incident Log # 001561-17 related to care of a resident.
Critical Incident Log # 006164-17 related to safety of a resident.
Complaint Log # 003666-17 related to responsive behaviours of a resident.
Complaint Log # 012210-17 related to care provided to a resident.
Complaint Log # 008202-17 related to medication administration.
Complaint Log # 008113-17 related to medication administration.
Complaint Log # 008146-17 related to medication administration.

During the course of the inspection, the inspector(s) spoke with the Interim Executive Director (IED), Interim Director of Care (IDOC), previous Executive Director, Previous Director of Care, Assistant Director of Care (ADOC), Director of Resident Programs and Admissions, Food Services Manager, Office Manager, Scheduling Coordinator, Registered Practical Nurse-Behavioural Support Ontario, Pharmacist, Maintenance team member, four Registered Nurses, four Registered Practical Nurses, eight Personal Support Workers, Resident Council President, Family Council Representative, three family members and 20 residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry of Health and Long-Term Care information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **5 VPC(s)**
- **4 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. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a written complaint was received concerning the care of a resident or the operation of the long-term care home, that complaint should immediately be forwarded to the Director.

A review of three written complaints from the complaint binder in the home for a specific period of time showed the following:
A written complaint submitted on a certain date showed concerns about a specific staff member not respecting the privacy of the resident on a specific time and date. The resident did not get a specific intervention which left them very uncomfortable all night.
A written complaint submitted on a certain date related to the neglect of a resident's certain area of personal care which caused a negative impact on the resident.
A written complaint submitted on a certain date expressing concerns on how a certain management team member of the home treated the front line staff and the impact of that on residents' care.

A review of the Critical Incident System (CIS) reports submitted by the home for the same period of time showed there was no record that the home submitted the written complaints to the Director.

In an interview, specific team members reviewed the complaints and acknowledged that no CIS submissions were completed. They said that the home's expectation would be that the home would forward any written complaint about the care of a resident or the operation of the home to the Director immediately.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was widespread. This non-compliance was not previously issued. [s. 22. (1)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, neglect of a resident by the licensee or staff, that the licensee knows of, or that is reported to the licensee, is immediately investigated and appropriate action is taken in response to every such incident.

The Ministry of Health received four complaints whereby complainants were concerned about the way a specific registered staff member had been completing the medication pass. Complainants said that they reported their concerns to the Administration of the home but they did not investigate their concerns and they seemed to brush them off.

In an interview a staff member said that on a specific date they had a meeting with another staff member and two management team members at that time. The two staff members submitted written letters of concerns from four different staff members related to that registered staff member. Letters showed that the registered staff member was completing the medication administration pass in a very short time compared to other nurses. They were giving medications without checking the Medication Administration Record (MAR), and not signing their administration at the time the medication was given. They reportedly kept the medication cart unlocked on several occasions when unattended. The staff reported concerns about residents to the registered staff member but they would not document or pass the information to upcoming shifts. The registered staff member was reportedly seen sleeping while on shift. The staff expressed concerns that this registered staff member was neglecting residents by not providing treatment or

providing treatments improperly. The staff said that the registered staff member did not complete their daily tasks in addition to unprofessional conduct towards residents and other staff members.

In an interview a staff member said "during the meeting the two management team members at that time were rude and did not seem interested in addressing those concerns, and they did not further talk to any of us or investigate the concerns".

Two specific staff members said in interviews that on a certain date they saw the registered staff member giving medications without checking the Electronic Medication Administration Record (EMAR). They were opening pill packs for the shift and putting them in medication cups and dispensing all medications at once. The two staff members picked up all the empty pill packs from the garbage and called the on call manager and informed them of the concerns. The on call manager told them that they would see what they could do.

The two specific staff members said that they waited for over an hour and didn’t hear back from the on call manager, they called again twice and there was no answer.
One of the staff members called a previous management team member and informed them that they need to come to the home immediately. The other staff member had to leave the home, they gave the empty packs to a registered team member.

The previous management team member came to the home with another manager. They took the empty packs from the registered team member and then met with the accused registered staff member and discussed the allegations. The staff member said that the previous management team member did not talk to them about their concerns.
A registered staff member said that several days later the previous management team member told them that because they did not put their concerns in writing then they will not be investigated. They said that the previous management team member did not talk to them or ask them about anything that happened on that shift. The other manager said in an interview that they came to the home with the management team member to take notes. They said that they did not interview any other staff member on that day.

The previous management team member said in a telephone interview that they interviewed the specific registered staff member and they had no reason to interview other staff members.

The specific on call manager said in an interview that they were called and informed of

the concerns related to medication administration. They said that they did not come to the home to immediately investigate the allegations.

In an interview, two specific team members acknowledged that allegations of abuse or neglect were not immediately or appropriately investigated. They said that the home's expectation was that every alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff would be immediately investigated. The investigation would include interviewing anyone that was aware or involved in the situations.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was a pattern. This non-compliance was not previously issued. [s. 23. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Findings/Faits saillants :

1. The licensee has failed to ensure that when a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident; or abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

In an interview, a specific manager acknowledged that while being on call on a certain date they received a call from a staff member informing them of concerns related to incompetent treatment or care of the residents by a specific registered staff member that may have resulted in harm or risk of harm to the residents. The manager said that they did not report those allegations to the Director immediately.

A specific previous management team member acknowledged in a telephone interview that on a certain date they received concerns and allegations related to improper treatment or care provided to the residents that put the residents at harm or risk of harm. They said that they did not report the allegations to the Director immediately.

A specific previous management team member acknowledged in a telephone interview that on a certain date they met with certain staff members of the home and received allegations related to incompetent treatment or care of the residents and allegations of abuse and neglect. They said that the other previous management team member was responsible for immediately reporting those allegations to the Director and if there was no CIS report then it was not done.

Two specific team members said that there was no record that the home had immediately reported those allegations to the Director. They said that the home's expectation was that any suspicions of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident; or abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred or may occur would be immediately reported to the Director.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was a pattern. This non-compliance was not previously issued isolated. [s. 24.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving 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, the attending physician and the Medical Director, that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, that corrective action was taken as necessary and a written record was kept of everything required, and that a quarterly review was undertaken of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, and changes and improvements identified were implemented and a written record was kept of everything provided for.

A review of six Medication Incident Reports for a specific period of time from the Medication Incidents Binder, showed that six out of six reports had no record of the immediate actions taken to assess and maintain the resident's health. Four out of the six reports had no record of reporting the incident to the resident or the resident's substitute decision-maker. Four out of the six reports had no record of informing the physician. Six out of the six reports were not reviewed or analyzed.

A review of the Medical Pharmacies policy #9-1 Medication Incident Reporting dated February 2017, showed that every medication incident and adverse drug reaction involving a resident (excluding) near miss was to be reported to the resident or the resident's substitute decision-maker, the Director of Nursing and Personal Care, the resident's attending physician and the pharmacy/Clinical Consultant Pharmacist, and all medication incidents were reviewed by the home 'interdisciplinary team' including the Administrator, the Director of Care, the Medical Director or prescriber and the Clinical Consultant Pharmacist. Changes and improvements identified in the review are to be

implemented and a written record kept on file at the home.

In an interview, two specific team members said that the expectation would be for the incident reports to be reviewed and analyzed at the Professional Advisory Committee (PAC) meetings that were held quarterly.

In an interview a specific staff member said that there was no review of the incidents that occurred during a specific period of time.

A review of the PAC meeting minutes with two specific team members showed that the meeting was completed on a certain date. There was no record of reviewing and analyzing all the medication incidents that occurred in that specified period of time.

The two specific team members said that the expectation was for every medication incident involving a resident and every adverse drug reaction to be documented, together with a record of the immediate actions taken to assess and maintain the resident's health, would be reported to the resident, the resident's substitute decision-maker, the attending physician and the Medical Director. All medication incidents and adverse drug reactions would be documented, reviewed and analyzed, corrective action was taken as necessary and a written record was kept of everything. A quarterly review would be undertaken of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, and changes and improvements identified were implemented and a written record was kept of everything provided for.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was a pattern. This non-compliance was not previously issued. [s. 135.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall 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. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to 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.

A review of the Registered Nurse staffing schedule for a specific period of time showed that 48 out of the 168 shifts (28.5 %) were covered by an agency Registered Nurse.

Two staff members acknowledged that Registered Nurses that were not employees of the home were being used to cover the vacant shifts, but they had the same nurses from the agency trained in the home to ensure consistency with care.

A specific staff member said that the expectation was for the home to have Registered Nurses that were staff of the home to be on duty and to provide nursing coverage at all times.

During the inspection this non-compliance was found to have the severity level of minimum risk. The scope of the non-compliance was a pattern. This non-compliance was previously issued as a Written Notification and Voluntary Plan of Correction on April 28, 2016, under Complaint Inspection #2016_243634_0005. [s. 8. (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 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that 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 was in compliance with and implemented in accordance with all applicable requirements under the Act.

Long-Term Care Homes O. Reg. 79/10, s. 136 (3) stated that the drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal
Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care.

A review of Medical Pharmacies policy #5-4 Drug Destruction and Disposal, dated February 2017, showed that staff would securely store surplus medication in the designated Stericycle container in a locked area within the home only accessible by

nursing staff. The surplus medication container was kept in the home until the licensed medical waste disposal company picked up the containers.

Two specific staff members said in interviews that nurses would place non-narcotic medications in the white bin, the staff did not open medication slips or containers and did not alter, denature or destroy the medications. When the white bin was full it would be closed and taken to a locked room for Stericycle to pick up. Stericycle would pick up the bin and would deal with the destruction of medication.

A specific staff member said that the home staff did not participate in the destruction of non-controlled substances.

Two specific staff member said that the expectation was for the policy to be in compliance with all applicable requirements under the Act. [s. 8. (1) (a)]

2. The licensee has failed to ensure that 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 was complied with.

LTCHA 2007, c. 8, s. 21 stated that every licensee of a long-term care home shall ensure that there were written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. .
O. Reg. 79/10, s. 100 stated that every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101.
O. Reg. 79/10, s. 101 (3) stated that the licensee shall ensure that:
(a) the documented record is reviewed and analyzed for trends at least quarterly;
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and
(c) a written record is kept of each review and of the improvements made in response

A review of the home's policy Complaints Management Program, policy # XXIII-A-10.40, dated August 2016, showed that the Care Community's Leadership and Quality Committee will on a quarterly basis, review, analyze and trend all complaints and will ensure the results of the review and analysis are used in determining what improvements may be required.

In an interview, two specific team members said that the quarterly review and analysis of the complaints record would be done during the Professional Advisory Committee meeting.
A review of the Professional Advisory Committee meeting minutes held on a certain date showed no discussions related to the complaints received for a specific period of time.

A review of the complaint record showed 10 documented complaints were received in that specific quarter.

Two specific team members acknowledged that there was no documented record that the complaints were analyzed and reviewed. They said that the expectation would be to review and analyze the trends of complaints in each quarter and comply with the home's policy.

During the inspection this non-compliance was found to have the severity level of minimum risk. The scope of the non-compliance was a pattern. This non-compliance was previously issued as a:
Written Notification and Compliance Order on May 15, 2017, under Complaint Inspection # 2017_363659_0002.
Written Notification on April 28, 2016, under Complaint Inspection # 2016_457630_0009.
Written Notification and Voluntary Plan of Correction on June 4, 2015, under Complaint Inspection # 2015_260521_0029.
Written Notification and Voluntary Plan of Correction on April 23, 2015, under Resident Q

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 Drug Destruction and Disposal policy was in compliance with all applicable requirements under the Act and the Complaint Management Program Policy was complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's plan of care was based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination.

A complaint was reported to the Ministry of Health and Long Term Care Infoline regarding a concern that a specific resident was found by a family member to be incontinent when they arrived at the home for a visit on a specific date.

A record review of Minimum Data Set (MDS) quarterly review assessment and the plan of care and Kardex on Point Click Care for a certain period of time showed that there were no interventions related to the resident's specific bowel continence strategies.

In an interview, two specific team members acknowledged that there were no plan of care interventions related to the resident's specific bowel continence strategies.

A specific team member said that the home's expectation was for the resident's plan of care to be based on the resident's continence assessment, including bladder and bowel elimination.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated. This non-compliance was not previously issued. [s. 26. (3) 8.]

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's plan of care was based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination, 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 has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A certain registered staff member said in an interview that a specific registered staff member administered the wrong dose of a certain drug to a certain resident on a specific date and time.

A clinical record review for the resident showed on that on that date and time the specific drug was not administered as ordered.

A specific team member acknowledged in an interview that the ordered medication was not administered as ordered.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated. This non-compliance was not previously issued. [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 were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's written record was kept up to date at all times.

A complaint was reported to the Ministry of Health and Long Term Care Infoline regarding a concern that a specific resident recently had falls resulting in a change of condition.

Review of the home's policy titled "Head Injury Routine" # XXI-BC-D-30.10 current revision date August 2016, stated the following:
"Any sudden impact or blow to the head is considered a head injury.
- Determine vital signs of resident - temperature, pulse, respiration, and blood pressure
- Determine level of consciousness, pupil size, and reaction
- Carry out head injury routine as per standard timelines and document on Head Injury Routine record:
- q 15 minutes x 1 hour
- q 1 hour x 4 hours
- q 4 hours x 24 hours".

A record review indicated that the resident had a fall on a certain date and time. The post fall assessment identified that a Head Injury Routine was started but there was no documentation of the monitoring of the resident's level of consciousness, vital signs or limb movement at a certain time post fall.

The resident had another fall at another date and time. A new Head Injury Routine was initiated but there was no documentation noted at certain times post fall.

The resident had a third fall at another date and time. A third Head Injury Routine was initiated but there was no documentation noted at certain times post fall.

A certain staff member acknowledged that the documentation was incomplete and said that the expectation was that registered staff were to complete the documentation on their assessments.

A record review of the progress notes indicated that the resident's physician was called by registered staff on a certain date and time to report change in condition and certain interventions applied. There was no information in the clinical records or progress notes related to the change in condition.

A certain staff member acknowledged that the expectation was to document any event with the resident, including the change in condition, in the clinical record to ensure records were kept up to date.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated. This non-compliance was not previously issued. [s. 231. (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 the resident's written record was kept up to date at all times, to be implemented voluntarily.

Issued on this 27th day of November, 2017

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) :	ALI NASSER (523), CAROLEE MILLINER (144), INA REYNOLDS (524)
Inspection No. / No de l'inspection :	2017_607523_0017
Log No. / No de registre :	014780-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 20, 2017
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Secord Trails Care Community 263 WONHAM STREET SOUTH, INGERSOLL, ON, N5C-3P6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JoAnn Zomer

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

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Order / Ordre :

The licensee shall ensure that when they receive a written complaint concerning the care of a resident or the operation of the long-term care home, the licensee shall immediately forward that complaint to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that when a written complaint was received concerning the care of a resident or the operation of the long-term care home, that complaint should immediately be forwarded to the Director.

A review of three written complaints from the complaint binder in the home for a specific period of time showed the following:
A written complaint submitted on a certain date showed concerns about a specific staff member not respecting the privacy of the resident on a specific time and date. The resident did not get a specific intervention which left them very uncomfortable all night.
A written complaint submitted on a certain date related to the neglect of a resident's certain area of personal care which caused a negative impact on the resident.
A written complaint submitted on a certain date expressing concerns on how a certain management team member of the home treated the front line staff and the impact of that on residents' care.

A review of the Critical Incident System (CIS) reports submitted by the home for the same period of time showed there was no record that the home submitted the written complaints to the Director.

In an interview, specific team members reviewed the complaints and acknowledged that no CIS submissions were completed. They said that the home's expectation would be that the home would forward any written complaint about the care of a resident or the operation of the home to the Director immediately.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was widespread. This non-compliance was not previously issued. [s. 22. (1)] (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee shall ensure that,
(a) Every alleged, suspected or witnessed incident of abuse of a resident by anyone, neglect of a resident by the licensee or staff, that the licensee knows of, or that is reported to the licensee, is immediately investigated.
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, neglect of a resident by the licensee or staff, that the licensee knows of, or that is reported to the licensee, is immediately investigated and appropriate action is taken in response to every such incident.

The Ministry of Health received four complaints whereby complainants were concerned about the way a specific registered staff member had been completing the medication pass. Complainants said that they reported their

concerns to the Administration of the home but they did not investigate their concerns and they seemed to brush them off.

In an interview a staff member said that on a specific date they had a meeting with another staff member and two management team members at that time. The two staff members submitted written letters of concerns from four different staff members related to that registered staff member. Letters showed that the registered staff member was completing the medication administration pass in a very short time compared to other nurses. They were giving medications without checking the Medication Administration Record (MAR), and not signing their administration at the time the medication was given. They reportedly kept the medication cart unlocked on several occasions when unattended. The staff reported concerns about residents to the registered staff member but they would not document or pass the information to upcoming shifts. The registered staff member was reportedly seen sleeping while on shift. The staff expressed concerns that this registered staff member was neglecting residents by not providing treatment or providing treatments improperly. The staff said that the registered staff member did not complete their daily tasks in addition to unprofessional conduct towards residents and other staff members.

In an interview a staff member said "during the meeting the two management team members at that time were rude and did not seem interested in addressing those concerns, and they did not further talk to any of us or investigate the concerns".

Two specific staff members said in interviews that on a certain date they saw the registered staff member giving medications without checking the Electronic Medication Administration Record (EMAR). They were opening pill packs for the shift and putting them in medication cups and dispensing all medications at once. The two staff members picked up all the empty pill packs from the garbage and called the on call manager and informed them of the concerns. The on call manager told them that they would see what they could do.

The two specific staff members said that they waited for over an hour and didn't hear back from the on call manager, they called again twice and there was no answer.
One of the staff members called a previous management team member and informed them that they need to come to the home immediately. The other staff member had to leave the home, they gave the empty packs to a registered team

member.

The previous management team member came to the home with another manager. They took the empty packs from the registered team member and then met with the accused registered staff member and discussed the allegations. The staff member said that the previous management team member did not talk to them about their concerns.
A registered staff member said that several days later the previous management team member told them that because they did not put their concerns in writing then they will not be investigated. They said that the previous management team member did not talk to them or ask them about anything that happened on that shift. The other manager said in an interview that they came to the home with the management team member to take notes. They said that they did not interview any other staff member on that day.

The previous management team member said in a telephone interview that they interviewed the specific registered staff member and they had no reason to interview other staff members.

The specific on call manager said in an interview that they were called and informed of the concerns related to medication administration. They said that they did not come to the home to immediately investigate the allegations.

In an interview, two specific team members acknowledged that allegations of abuse or neglect were not immediately or appropriately investigated. They said that the home's expectation was that every alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff would be immediately investigated. The investigation would include interviewing anyone that was aware or involved in the situations.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was a pattern. This non-compliance was not previously issued. [s. 23. (1)] (523)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Order / Ordre :

The licensee shall ensure that when a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident; or abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that when a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident; or abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

In an interview, a specific manager acknowledged that while being on call on a certain date they received a call from a staff member informing them of concerns related to incompetent treatment or care of the residents by a specific registered staff member that may have resulted in harm or risk of harm to the residents. The manager said that they did not report those allegations to the Director immediately.

A specific previous management team member acknowledged in a telephone interview that on a certain date they received concerns and allegations related to improper treatment or care provided to the residents that put the residents at harm or risk of harm. They said that they did not report the allegations to the Director immediately.

A specific previous management team member acknowledged in a telephone

interview that on a certain date they met with certain staff members of the home and received allegations related to incompetent treatment or care of the residents and allegations of abuse and neglect. They said that the other previous management team member was responsible for immediately reporting those allegations to the Director and if there was no CIS report then it was not done.

Two specific team members said that there was no record that the home had immediately reported those allegations to the Director. They said that the home's expectation was that any suspicions of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident; or abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred or may occur would be immediately reported to the Director.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was a pattern. This non-compliance was not previously issued isolated. [s. 24.] (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2017

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Order / Ordre :

The licensee shall ensure:
• That every medication incident involving 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 reported to the resident, the resident's substitute decision-maker, the attending physician and the Medical Director.
• That all medication incidents and adverse drug reactions are documented, reviewed and analyzed, that corrective action is taken as necessary and a written record is kept of everything required,
• That a quarterly review is undertaken of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, and changes and improvements identified were implemented and a written record was kept of everything provided for.

Grounds / Motifs :

1. The licensee has failed to ensure that every medication incident involving 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, the attending physician and the Medical Director, that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, that corrective action was taken as necessary and a written record was kept of everything required, and that a quarterly review was undertaken of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, and changes and improvements identified were implemented and a written record was kept of everything provided for.

A review of six Medication Incident Reports for a specific period of time from the Medication Incidents Binder, showed that six out of six reports had no record of the immediate actions taken to assess and maintain the resident's health. Four out of the six reports had no record of reporting the incident to the resident or the resident's substitute decision-maker. Four out of the six reports had no record of informing the physician. Six out of the six reports were not reviewed or analyzed.

A review of the Medical Pharmacies policy #9-1 Medication Incident Reporting dated February 2017, showed that every medication incident and adverse drug reaction involving a resident (excluding) near miss was to be reported to the resident or the resident's substitute decision-maker, the Director of Nursing and Personal Care, the resident's attending physician and the pharmacy/Clinical Consultant Pharmacist, and all medication incidents were reviewed by the home 'interdisciplinary team' including the Administrator, the Director of Care, the Medical Director or prescriber and the Clinical Consultant Pharmacist. Changes and improvements identified in the review are to be implemented and a written record kept on file at the home.

In an interview, two specific team members said that the expectation would be for the incident reports to be reviewed and analyzed at the Professional Advisory Committee (PAC) meetings that were held quarterly.

In an interview a specific staff member said that there was no review of the incidents that occurred during a specific period of time.

A review of the PAC meeting minutes with two specific team members showed that the meeting was completed on a certain date. There was no record of reviewing and analyzing all the medication incidents that occurred in that specified period of time.

The two specific team members said that the expectation was for every medication incident involving a resident and every adverse drug reaction to be documented, together with a record of the immediate actions taken to assess and maintain the resident's health, would be reported to the resident, the resident's substitute decision-maker, the attending physician and the Medical Director. All medication incidents and adverse drug reactions would be documented, reviewed and analyzed, corrective action was taken as necessary and a written record was kept of everything. A quarterly review would be undertaken of all medication incidents and adverse drug reactions that occurred

in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, and changes and improvements identified were implemented and a written record was kept of everything provided for.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was a pattern. This non-compliance was not previously issued. [s. 135.] (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2017

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 20th day of October, 2017

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

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Name of Inspector / Nom de l'inspecteur : Ali Nasser

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