Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 18, 2020	2020_725522_0005	015575-20	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 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

JULIE LAMPMAN (522)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 5, 6, 7, 21, 24, 2020

The following Critical Incident System (CIS) intake was inspected during this Critical Incident System Inspection:
CIS #2628-000016-20/Log #015575-20 related to an incident involving a resident.

PLEASE NOTE:
A Written Notification, Compliance Order and Director's Referral related to LTCHA, 2007, c.8, s. 19 (1) was identified in this inspection and has been issued in Inspection Report #2020_725522_0004, which was conducted concurrently with this inspection.

A Voluntary Plan of Correction related to Ontario Regulation 79/10, s. 8 (1) (b) identified in concurrent Complaint Inspection #2020_725522_0003 (Log#012700-20, 013158-20, 013561-20, 014915-20) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Acting Executive Director, the Director of Care, the Acting Assistant Director of Care, the Director of Clinical Services, a Physician, a Coroner, Registered Nurses, Registered Practical Nurses and Personal Support Workers.

The inspector(s) also reviewed resident clinical records and policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **3 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) related to an incident involving resident #001.

Review of the resident's clinical record noted the resident #001 had a diagnosis that required monitoring.

Review of the resident's most recent care plan noted the diagnosis had not been included in the resident's care plan.

There was no documentation in the resident's plan of care related to monitoring for signs and symptoms of complications related to their diagnosis and parameters of when the resident's physician should be contacted.

Review of the resident's physician orders noted the resident was to be monitored one time a day every 28 days and as needed, for complications related to their diagnosis. There was no further direction in the orders.

B) Review of resident #004's clinical record noted the resident had a diagnosis that required monitoring.

Review of the resident's most recent care plan noted a focus which indicated the resident

had a nutritional problem or potential nutritional problem related to their diagnosis which put them at high risk. The resident's plan of care also stated the resident often refused diagnosis specific medication and monitoring.

There was no documentation in the resident's plan of care related to monitoring for signs and symptoms of complications related to their diagnosis and parameters of when the resident's physician should be contacted.

C) Review of resident #006's clinical record noted the resident had a diagnosis that required monitoring.

i) Review of the resident's most recent care plan noted a focus which indicated the resident had a nutritional problem or potential nutritional problem related to their diagnosis which put them at high risk.

There was no documentation in the resident's plan of care related to monitoring for signs and symptoms of complications related to their diagnosis and parameters of when the resident's physician should be contacted.

ii) Review of resident #006's physician orders noted the resident was to be monitored four times a day for complications due to their diagnosis. There was no further direction in the orders.

Review of the resident's electronic Medication Administration Record (eMAR) noted the resident had been administered an emergency dose of medication in August 2020, as the registered staff had contacted the resident's physician with concerns regarding results from the resident's monitoring.

Further review of the resident's eMAR noted 11 times where the documented results were higher than those in August 2020, with no interventions.

iii) Resident #006 also had an order for medication before meals. There was no further direction in the orders on when the medication should be held.

Review of the resident's eMAR noted the medication was held on five times in June and one time in July 2020, due to the results of monitoring.

Further review of the resident's eMAR noted 34 times between June and August 2020,

where the documented results were less than the results when the medication had been held in June and July, with no interventions.

In an interview, Acting Assistant Director of Care (aADOC) stated a resident's plan of care should include what the staff should watch specific to each resident when monitoring, steps to take if a resident was being monitored for complications related to their diagnosis and parameters for when to call the physician.

The licensee has failed to ensure that the plans of care for residents #001, 004 and #006 provided clear direction to the management of the residents' specific diagnosis and monitoring of the complications related to the diagnosis. [s. 6. (1) (c)]

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

Review of resident #004's clinical record noted the resident had a diagnosis which required monitoring.

Review of the resident's physician's orders noted the resident was to be monitored before meals and at bedtime and the resident was to receive medication if the monitoring noted certain results.

Review of the resident's electronic Medication Administration Record (eMAR) noted three occasions where the medication had not been given as ordered.

In an interview, Registered Nurse (RN) #113 stated if monitoring of the resident noted specific results there was an order to administer medication to the resident. The RN stated registered staff should have administered the medication to the resident as per the doctor's orders.

The licensee has failed to ensure that medication was provided to resident #006 as specified in the plan. [s. 6. (7)]

Additional Required Actions:

CO # - 001, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure where the Act or Regulations required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

Ontario Regulation 68 (2) (a) states every licensee of a long-term care home shall ensure that the nutrition and hydration programs include policies and procedures relating to nutrition care and dietary services and hydration.

Two complaints were received by the Ministry of Long-Term Care related to concerns about the care provided to resident #011 including that the resident had a significant weight loss since their admission to the home.

Review of the home's "Monitoring Resident Weights" policy noted in part that all residents would be weighed monthly and their weights would be recorded.

The policy further stated that an unplanned weight loss of 5% in 30 days, 7.5 % in 90 days and any other weight change that compromised a resident's health status, would be assessed, evaluated, and documented and a Registered Dietitian (RD) referral may be

required.

Review of the resident's weights in Point Click Care (PCC) noted the resident had lost 24 kilograms (31.5 %) in less than two months.

Review of the resident's progress notes noted a Dietitian assessment that stated the resident had not been weighed the month of the assessment.

In an interview, the Registered Dietitian (RD) stated the resident should have had a weight the beginning of the month and they had to ask that the resident be weighed. The RD stated when the resident was weighed, significant weight loss was noted and they have ordered frequent weights for the resident.

During two separate interviews, the Director of Care (DOC) stated staff had 10 days at the beginning of the month to ensure residents' weights were completed and if weights were not completed staff would approach the personal support worker to complete the weight as they were done at bath time. The DOC stated they would expect that the resident had a weight completed within the first 10 days of the month.

The licensee has failed to ensure that the home's "Monitoring Resident Weights" policy was complied with. [s. 8. (1) (b)]

2. Long-Term Care Homes Act 2007, S.O. 2007, c. 8 s. 8 (1) (a) states, "Every licensee of a long-term care home shall ensure that there is an organized program of nursing services for the home to meet the assessed needs of the residents."

Ontario Regulation 79/10, s. 30 (1) requires the organized programs of nursing services to have policies.

Review of the home's Blood Glucose Monitoring Guidelines policy noted in part, if blood glucose results were abnormally high or low compared to the resident's usual blood glucose values staff were to repeat the procedure, recalibrate the glucometer, attempt with a new glucometer and notify the physician of the abnormal value.

Review of the home's Hyperglycemia policy noted in part that the nurse will:
1) Monitor for fatigue, confusion, frequent urination, or increased incontinence
2) Monitor for infection or acute illness
3) Monitor for dehydration

4) Ensure residents receive total fluid intake
5) Immediately obtain a blood glucose reading”

A) Review of resident #001’s electronic progress notes in Point Click Care (PCC) noted registered staff had documented that the resident had a high blood glucose with no follow up from the staff member who obtained the blood glucose level.

Further review of the resident’s progress notes noted no documentation related to the resident’s elevated blood glucose nor further documentation related to monitoring the resident during the oncoming shifts after the elevated blood glucose or notification of the resident’s physician.

B) Review of resident #004’s clinical record noted the resident was administered medication due to a high blood glucose level and the medication was noted as ineffective.

Review of the resident’s progress notes noted no documentation or follow up when the resident was administered the medication and it was noted as ineffective.

In an interview, Registered Nurse #113 stated when the medication was administered to the resident and it was noted as ineffective registered staff should have contacted the resident’s physician for further direction.

In an interview, Acting Assistant Director of Care (aADOC) #107 when the medication was administered to the resident and it was noted as ineffective registered staff should have contacted the resident’s physician for further direction and documented it in the resident’s progress notes and rechecked the resident’s blood glucose.

C) Review of the home's Hypoglycemia Guidelines policy noted in part that in cases of severe hypoglycemia unconsciousness may occur.

Review of the home's Hypoglycemia Care of the Unconscious Resident who is Experiencing Hypoglycemia policy noted in part that staff should assess the resident, check the resident’s blood glucose (BG) and notify the Medical Director, the attending physician, the Director of Care and the resident’s substitute decision maker (SDM) of the incident.

A further review of resident #001’s electronic progress notes in PCC noted that the

resident had an incident of unresponsiveness, but the resident's BG had not been checked. The progress note indicated the oncoming shift had been made aware and were to continue to monitor the resident.

There were no further progress notes entered for the resident in PCC until two days after the incident. There was no documented monitoring of the resident after the incident of unresponsiveness, no documented BG checks and no documentation that the resident's SDM was notified of the incident.

The resident's physician entered a progress note which noted that they had been faxed about the incident two days after it had occurred and indicated they should have been notified in a timelier manner. The physician's note also indicated that the resident had not had vitals completed after the incident, did not have their BG checked and the resident's SDM had not been notified of the incident.

In an interview, Registered Practical Nurse (RPN) #104 stated they had not checked the resident's blood glucose and did not give a reason for not checking the resident's BG. The RPN stated they had checked the resident's vitals after the incident and acknowledged there was no documented vitals in PCC for the resident after the incident. The RPN stated they had informed the oncoming shift regarding monitoring the resident. The RPN reviewed the resident's progress notes and acknowledged that there was no documented monitoring of the resident after the incident. The RPN stated they could not recall if the resident's SDM had been notified of the incident and acknowledged there was no documentation regarding the notification of the SDM.

In an interview, Acting Assistant Director of Care (aADOC) stated when resident #001 had an elevated BG they would expect staff to call the doctor immediately and take direction from the doctor and let the family know what happened. The aADOC stated if a resident was unresponsive the first thing they would check would be their BG to see if they were hypoglycemic. The aADOC stated the incident should be reported to the oncoming shift and the resident should be monitored for at least 24 to 48 hours, vital signs should be taken and the resident's consumption of food should be reviewed.

The licensee has failed to ensure that the home's Blood Glucose Monitoring Guidelines, Hyperglycemia and Hypoglycemia Guidelines Care of the Unconscious Resident policies were complied with. [s. 8. (1) (b)]

3. Ontario Regulation 79/10 s.48 (1) 3. requires the home to have a continence care and

bowel management program.

Ontario Regulation 79/10 s. 30 (1) 1. requires the continence care and bowel management program to have policies and procedures.

Review of the home's "Continence Program – Products" noted in part that continence/incontinence care products were available to all residents. The policy stated that that an emergency supply of continence care products was available within the home.

Two complaints were received by the Ministry of Long-Term Care related to staffing and care concerns in the home.

In an interview, Registered Practical Nurse (RPN) #116 informed the Inspector that on a weekend in July 2020, there were not enough incontinence briefs in the home and residents were put in the incorrect brief. The RPN stated the majority of residents wore medium or large, so residents who required medium were in large and residents who required large were in XL or double XL or some residents used comfort day pads. The RPN stated some residents were in pull ups even though they were total care and total change, because that was the most appropriate size they could find for that resident.

In an interview, the Acting Assistant Director of Care (aADOC) was asked if the home had a system in place to make sure they had enough briefs for the residents. The aADOC stated that before the process was completed by the previous ADOC and that they only relied on staff putting in a request in to change brief size for a resident, but staff had not been following the process. The aADOC stated that the list for residents' briefs and count had not been updated since October 2019. When asked by the Inspector if there was a weekend where residents didn't have briefs, that they were short of briefs the aADOC stated on the weekend in July 2020, the home was short of briefs. The aADOC stated they have now assessed almost all residents for brief size.

The licensee has failed to ensure that the home's "Continence Program – Products" policy was complied with. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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's "Monitoring Resident Weights" and "Continence Program – Products" policies are complied, to be implemented voluntarily.

Issued on this 22nd day of September, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE LAMPMAN (522)
Inspection No. / No de l'inspection :	2020_725522_0005
Log No. / No de registre :	015575-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 18, 2020
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, 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 :	Tammy Smith

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 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. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must comply with s. 6 (1) (c) of LTCHA 2007.

Specifically, the licensee must ensure:
a) The plan of care for all residents that have a diagnosis that requires monitoring includes a focus for managing the residents diagnosis;
b) The plan of care for residents #001, #004 and #006 and all other residents include monitoring for signs and symptoms of complications due to their diagnosis specific to that resident; including parameters of acceptable levels for the resident and when to contact the resident's physician.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) related to an incident involving resident #001.

Review of the resident's clinical record noted the resident #001 had a diagnosis that required monitoring.

Review of the resident's most recent care plan noted the diagnosis had not been included in the resident's care plan.

There was no documentation in the resident's plan of care related to monitoring for signs and symptoms of complications related to their diagnosis and parameters of when the resident's physician should be contacted.

Review of the resident's physician orders noted the resident was to be monitored one time a day every 28 days and as needed, for complications related to their diagnosis. There was no further direction in the orders.

B) Review of resident #004's clinical record noted the resident had a diagnosis that required monitoring.

Review of the resident's most recent care plan noted a focus which indicated the resident had a nutritional problem or potential nutritional problem related to their diagnosis which put them at high risk. The resident's plan of care also stated the resident often refused diagnosis specific medication and monitoring.

There was no documentation in the resident's plan of care related to monitoring for signs and symptoms of complications related to their diagnosis and parameters of when the resident's physician should be contacted.

C) Review of resident #006's clinical record noted the resident had a diagnosis that required monitoring.

i) Review of the resident's most recent care plan noted a focus which indicated the resident had a nutritional problem or potential nutritional problem related to their diagnosis which put them at high risk.

There was no documentation in the resident's plan of care related to monitoring for signs and symptoms of complications related to their diagnosis and parameters of when the resident's physician should be contacted.

ii) Review of resident #006's physician orders noted the resident was to be monitored four times a day for complications due to their diagnosis. There was no further direction in the orders.

Review of the resident's electronic Medication Administration Record (eMAR) noted the resident had been administered an emergency dose of medication in

August 2020, as the registered staff had contacted the resident's physician with concerns regarding results from the resident's monitoring.

Further review of the resident's eMAR noted 11 times where the documented results were higher than those in August 2020, with no interventions.

iii) Resident #006 also had an order for medication before meals. There was no further direction in the orders on when the medication should be held.

Review of the resident's eMAR noted the medication was held on five times in June and one time in July 2020, due to the results of monitoring.

Further review of the resident's eMAR noted 34 times between June and August 2020, where the documented results were less than the results when the medication had been held in June and July, with no interventions.

In an interview, Acting Assistant Director of Care (aADOC) stated a resident's plan of care should include what the staff should watch specific to each resident when monitoring, steps to take if a resident was being monitored for complications related to their diagnosis and parameters for when to call the physician.

The licensee has failed to ensure that the plans of care for residents #001, 004 and #006 provided clear direction to the management of the residents' specific diagnosis and monitoring of the complications related to the diagnosis.

The severity of this issue was determined to be a level 3 as there was actual risk to residents. The scope of the issue was level 3 as it was widespread, involving three three of three residents. The home has a level 2 compliance history as there was previous non-compliance to a different subsection of the LTCHA. (522)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 29, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must comply with s. 8 (1) (b) of Ontario Regulation 79/10.

Specifically, the licensee must ensure:
a) The home's policies related to diabetes management of hyperglycemia and hypoglycemia and blood glucose monitoring are complied with.
b) All registered staff receive training on the home's diabetic management of hyperglycemia and hypoglycemia and blood glucose monitoring. A written record of attendees must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure where the Act or Regulations required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

Ontario Regulation 68 (2) (a) states every licensee of a long-term care home shall ensure that the nutrition and hydration programs include policies and procedures relating to nutrition care and dietary services and hydration.

Two complaints were received by the Ministry of Long-Term Care related to concerns about the care provided to resident #011 including that the resident had a significant weight loss since their admission to the home.

Review of the home's "Monitoring Resident Weights" policy noted in part that all

residents would be weighed monthly and their weights would be recorded.

The policy further stated that an unplanned weight loss of 5% in 30 days, 7.5 % in 90 days and any other weight change that compromised a resident's health status, would be assessed, evaluated, and documented and a Registered Dietitian (RD) referral may be required.

Review of the resident's weights in Point Click Care (PCC) noted the resident had lost 24 kilograms (31.5 %) in less than two months.

Review of the resident's progress notes noted a Dietitian assessment that stated the resident had not been weighed the month of the assessment.

In an interview, the Registered Dietitian (RD) stated the resident should have had a weight the beginning of the month and they had to ask that the resident be weighed. The RD stated when the resident was weighed, significant weight loss was noted and they have ordered frequent weights for the resident.

During two separate interviews, the Director of Care (DOC) stated staff had 10 days at the beginning of the month to ensure residents' weights were completed and if weights were not completed staff would approach the personal support worker to complete the weight as they were done at bath time. The DOC stated they would expect that the resident had a weight completed within the first 10 days of the month.

The licensee has failed to ensure that the home's "Monitoring Resident Weights" policy was complied with. [s. 8. (1) (b)]

2. Long-Term Care Homes Act 2007, S.O. 2007, c. 8 s. 8 (1) (a) states, "Every licensee of a long-term care home shall ensure that there is an organized program of nursing services for the home to meet the assessed needs of the residents."

Ontario Regulation 79/10, s. 30 (1) requires the organized programs of nursing services to have policies.

Review of the home's Blood Glucose Monitoring Guidelines policy noted in part,

if blood glucose results were abnormally high or low compared to the resident's usual blood glucose values staff were to repeat the procedure, recalibrate the glucometer, attempt with a new glucometer and notify the physician of the abnormal value.

Review of the home's Hyperglycemia policy noted in part that the nurse will:
1) Monitor for fatigue, confusion, frequent urination, or increased incontinence
2) Monitor for infection or acute illness
3) Monitor for dehydration
4) Ensure residents receive total fluid intake
5) Immediately obtain a blood glucose reading"

A) Review of resident #001's electronic progress notes in Point Click Care (PCC) noted registered staff had documented that the resident had a high blood glucose with no follow up from the staff member who obtained the blood glucose level.

Further review of the resident's progress notes noted no documentation related to the resident's elevated blood glucose nor further documentation related to monitoring the resident during the oncoming shifts after the elevated blood glucose or notification of the resident's physician.

B) Review of resident #004's clinical record noted the resident was administered medication due to a high blood glucose level and the medication was noted as ineffective.

Review of the resident's progress notes noted no documentation or follow up when the resident was administered the medication and it was noted as ineffective.

In an interview, Registered Nurse #113 stated when the medication was administered to the resident and it was noted as ineffective registered staff should have contacted the resident's physician for further direction.

In an interview, Acting Assistant Director of Care (aADOC) #107 when the medication was administered to the resident and it was noted as ineffective registered staff should have contacted the resident's physician for further

direction and documented it in the resident's progress notes and rechecked the resident's blood glucose.

C) Review of the home's Hypoglycemia Guidelines policy noted in part that in cases of severe hypoglycemia unconsciousness may occur.

Review of the home's Hypoglycemia Care of the Unconscious Resident who is Experiencing Hypoglycemia policy noted in part that staff should assess the resident, check the resident's blood glucose (BG) and notify the Medical Director, the attending physician, the Director of Care and the resident's substitute decision maker (SDM) of the incident.

A further review of resident #001's electronic progress notes in PCC noted that the resident had an incident of unresponsiveness, but the resident's BG had not been checked. The progress note indicated the oncoming shift had been made aware and were to continue to monitor the resident.

There were no further progress notes entered for the resident in PCC until two days after the incident. There was no documented monitoring of the resident after the incident of unresponsiveness, no documented BG checks and no documentation that the resident's SDM was notified of the incident.

The resident's physician entered a progress note which noted that they had been faxed about the incident two days after it had occurred and indicated they should have been notified in a timelier manner. The physician's note also indicated that the resident had not had vitals completed after the incident, did not have their BG checked and the resident's SDM had not been notified of the incident.

In an interview, Registered Practical Nurse (RPN) #104 stated they had not checked the resident's blood glucose and did not give a reason for not checking the resident's BG. The RPN stated they had checked the resident's vitals after the incident and acknowledged there was no documented vitals in PCC for the resident after the incident. The RPN stated they had informed the oncoming shift regarding monitoring the resident. The RPN reviewed the resident's progress notes and acknowledged that there was no documented monitoring of the resident after the incident. The RPN stated they could not recall if the resident's

SDM had been notified of the incident and acknowledged there was no documentation regarding the notification of the SDM.

In an interview, Acting Assistant Director of Care (aADOC) stated when resident #001 had an elevated BG they would expect staff to call the doctor immediately and take direction from the doctor and let the family know what happened. The aADOC stated if a resident was unresponsive the first thing they would check would be their BG to see if they were hypoglycemic. The aADOC stated the incident should be reported to the oncoming shift and the resident should be monitored for at least 24 to 48 hours, vital signs should be taken and the resident's consumption of food should be reviewed.

The licensee has failed to ensure that the home's Blood Glucose Monitoring Guidelines, Hyperglycemia and Hypoglycemia Guidelines Care of the Unconscious Resident policies were complied with. [s. 8. (1) (b)]

3. Ontario Regulation 79/10 s.48 (1) 3. requires the home to have a continence care and bowel management program.

Ontario Regulation 79/10 s. 30 (1) 1. requires the continence care and bowel management program to have policies and procedures.

Review of the home's "Continence Program – Products" noted in part that continence/incontinence care products were available to all residents. The policy stated that that an emergency supply of continence care products was available within the home.

Two complaints were received by the Ministry of Long-Term Care related to staffing and care concerns in the home.

In an interview, Registered Practical Nurse (RPN) #116 informed the Inspector that on a weekend in July 2020, there were not enough incontinence briefs in the home and residents were put in the incorrect brief. The RPN stated the majority of residents wore medium or large, so residents who required medium were in large and residents who required large were in XL or double XL or some residents used comfort day pads. The RPN stated some residents were in pull ups even though they were total care and total change, because that was the

most appropriate size they could find for that resident.

In an interview, the Acting Assistant Director of Care (aADOC) was asked if the home had a system in place to make sure they had enough briefs for the residents. The aADOC stated that before the process was completed by the previous ADOC and that they only relied on staff putting in a request in to change brief size for a resident, but staff had not been following the process. The aADOC stated that the list for residents' briefs and count had not been updated since October 2019. When asked by the Inspector if there was a weekend where residents didn't have briefs, that they were short of briefs the aADOC stated on the weekend in July 2020, the home was short of briefs. The aADOC stated they have now assessed almost all residents for brief size.

The licensee has failed to ensure that the home's "Continence Program – Products" policy was complied with.

The severity of this issue was determined to be a level 3 as there was actual risk to residents. The scope of the issue was level 3 as it was widespread involving one out of three residents. The home has a level 3 compliance history as there was previous non-compliance to the same subsection of the LTCHA that included:
• Voluntary Plan of Correction (VPC) issued June 11, 2020, (#2020_607523_0013);
• VPC issued February 27, 2020, (#2019_725522_0018);
• VPC issued October 20, 2017, (#2017_607523_0017).
(522)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 29, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 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. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must comply with s. 6 (7) of LTCHA 2007.

Specifically, the licensee must ensure:
a) Resident #004 and all other residents are administered medication as per their plan of care.

Grounds / Motifs :

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

Review of resident #004's clinical record noted the resident had a diagnosis which required monitoring.

Review of the resident's physician's orders noted the resident was to be monitored before meals and at bedtime and the resident was to receive medication if the monitoring noted certain results.

Review of the resident's electronic Medication Administration Record (eMAR) noted three occasions where the medication had not been given as ordered.

In an interview, Registered Nurse (RN) #113 stated if monitoring of the resident noted specific results there was an order to administer medication to the resident. The RN stated registered staff should have administered the medication to the resident as per the doctor's orders.

The licensee has failed to ensure that medication was provided to resident #006 as specified in the plan.

The severity of this issue was determined to be a level 3 as there was actual risk to the resident. The scope of the issue was level 1 as it was isolated involving one out of three residents. The home has a level 3 compliance history as there was previous non-compliance to the same subsection of the LTCHA that included:
•Written Notification (WN) issued February 27, 2020, (#2019_725522_0018).
•Voluntary Plan of Correction (VPC) issued November 22, 2018, (#2018_722630_0024). (522)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 29, 2021

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 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 18th day of September, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Lampman

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