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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 18, 2020	2020_725522_0003	012700-20, 013158-20, 013561-20, 014915-20	Complaint

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), HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 8, 9, 10, 13, 14, 15, 16, 17, 20, 21, 22, 23, 24, 28, 29, 30, 31, August 4, 5, 6, 7, 2020.

The following complaint intakes were inspected:

Log #012700-20/ IL-79584-LO, IL-79788-LO, IL-79870-LO related to allegations of improper care;
Log #013158-20/ IL-79784-LO related to staffing and training of new hires;
Log #013561-20/ IL-80018-LO related to 24/7 nursing;
Log #014915-20/IL-80571-LO related to allegations of neglect.

PLEASE NOTE:
A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 24 (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) was identified in this inspection and has been issued in Inspection Report #2020_725522_0005, which was conducted concurrently with this inspection.

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 Support Services, the Scheduling Coordinator, a Physician, a Registered Dietitian, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Care Support Aides and residents.

The inspector(s) also observed resident care, staff to resident interactions, reviewed resident clinical records, the home's daily staffing roster, the home's staffing contingency plan and policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Sufficient Staffing

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Two complaints were received by the Ministry of Long-Term Care related to concerns of improper care provided to resident #001.

In an interview, the resident's Power of Attorney (POA) stated they had concerns regarding the care the resident had received since their admission to the home.

The complainant stated the resident had a significant weight loss, had declined, was very weak, had several falls and that it had taken two weeks for the resident to receive antibiotics for an infection.

The complainant stated on one occasion they insisted the resident be sent to hospital and the resident was diagnosed with dehydration and an infection. The complainant stated on another occasion they took the resident to hospital themselves where the resident was again diagnosed with an infection.

Review of the resident's admission care plan noted the resident required set up only for eating, one team member assistance for toileting and one person assist for walking and locomotion.

Review of the resident's most recent care plan noted the resident required total assistance of one team member for meals, one to two staff assistance for toileting. The resident required one to two staff assistance with locomotion or use of an assistive device with one staff assistance and that the resident was a one to two person transfer.

Review of resident #001's electronic progress notes in Point Click Care (PCC) noted the resident had four falls within eight days. After the fourth fall a sample had been sent to the lab for the resident as staff had suspected the resident had an infection.

Four days after the sample was sent, results revealed the sample had been contaminated and another sample was sent three days after the home was notified.

After the second sample was sent the resident was noted to have increased confusion

and had three more falls.

There was no documentation to support that that the POA's request to send the resident to hospital to be tested for an infection and started on antibiotics was discussed with the resident's physician, nor was it discussed with the oncall physician. There was no documentation to support that either physician was made aware of the number of falls the resident had up to and since the resident had a sample sent to determine if the resident had an infection.

Eleven days after the first sample was sent to determine if the resident had an infection, the resident was started on antibiotics. The resident had another fall the next day. Seven days after the resident had started on antibiotics, progress notes indicated the resident was drowsy and weak and the family had expressed concerns that the resident could not speak on the phone.

The Director of Care (DOC) stated in the resident's progress notes that they had spoken to the resident's POA about the resident's dementia process and that the resident's treatment had just finished for an infection. The POA had questioned whether the resident may have had a stroke and DOC indicated that the resident did not have a stroke. The POA requested that the resident be transferred to the hospital for further medical assessment. The DOC contacted the resident's physician and the resident was sent to hospital where the resident was diagnosed with dehydration and an infection.

Two days later progress notes indicated the resident was more alert, bright and talking to staff. The resident was required to be fed by staff and staff encouraged fluid intake.

Progress notes indicated nine days after the resident had been seen at the hospital, the resident had been eating less than half of their meals. The notes indicated the resident was drowsy, very weak and had no energy.

The resident's POA had taken the resident out for an appointment and took the resident to the hospital where the resident was diagnosed with two infections and started on antibiotics.

During two separate interviews, Registered Practical Nurse (RPN) #106 stated resident #001 had quite a few falls and they had called the resident's physician to get a sample to send to determine if the resident had an infection. The RPN stated the resident did not have any falls since they began treatment for the infection.

The RPN stated the resident had difficulty with eating and drinking and needed a lot of encouragement and they were monitoring the resident's food and fluid intake. The RPN stated the resident was independent with eating and were ambulatory when they were first admitted and when the resident started to decline, they required total assistance with feeding, which they still received and now used a an assistive device. The RPN stated that the resident had lost a significant amount of weight since they were admitted which the RPN attributed to fluid loss.

The RPN stated there had been no discussion with staff and management about sending the resident to the hospital. The RPN stated they had spoken with the resident's POA who requested that the resident be sent to hospital to be tested for an infection. The RPN stated they had left a note in the registered staff day planner for staff to follow up with the resident's physician. The RPN reviewed the schedule and noted an agency staff member had worked that day and did not follow up with the resident's physician.

In an interview, the resident's Physician stated they had started the resident on a mild opioid and they did not think it would cause significant lethargy. The Physician stated they had never observed the resident in a state of confusion or difficult to rouse. The Physician stated they did not feel the significant change in the resident's status was related to their dementia process as the resident always addressed the Physician appropriately.

When asked about the two week delay in the resident receiving antibiotic therapy, the Physician stated they liked to see the test result before giving an antibiotic but if they had of been made aware that the resident had several falls while waiting for the test results they would have expected that the resident was sent to hospital to be tested.

During two separate interviews, the Director of Care (DOC) acknowledged that they had spoken to the resident's POA. The DOC stated they were aware staff had sent a sample to be tested for the resident as the resident's status had changed. The DOC stated they were aware of the length of time it had taken to get the test results and they had called the lab. When the Inspector asked the DOC if they were concerned regarding the number of falls the resident had while waiting to start antibiotics, the DOC stated the resident was a high risk for falls and they could not prevent the resident from falling just put interventions in place to prevent injury. When asked by the Inspector why resident had not been sent to hospital to be tested due to their falls and change in condition, the DOC stated they did everything the resident needed after their falls and put interventions

in place.

The DOC stated when the resident's POA brought forward concerns regarding the resident's decline and wanted the resident to be sent to hospital, they told the POA the resident's decline was part of the resident's dementia process. When the Inspector asked the DOC if during that time they had physically assessed the resident, the DOC stated they did not assess the resident. The DOC acknowledged that the resident was sent to the hospital after the discussion with the resident's POA and diagnosed with an infection and dehydration.

The licensee has failed to ensure that resident #001 was reassessed and their plan of care reviewed and revised when the resident's care needs changed.[s. 6. (10) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The has licensee failed to ensure the registered dietitian who was a member of the staff of the home completed a nutritional assessment whenever there was a significant change in the resident's health condition.

Two complaints were received by the Ministry of Long-Term Care related to concerns of improper care provided to resident #001.

In an interview, the resident's Power of Attorney (POA) stated they had concerns regarding the care the resident had received since their admission to the home.

The complainant stated the resident had a significant weight loss, had declined, was very weak, had several falls and that it had taken two weeks for the resident to receive antibiotics for an infection.

The complainant stated on one occasion they insisted the resident be sent to hospital and the resident was diagnosed with dehydration and an infection. The complainant stated on another occasion they took the resident to hospital themselves where the resident was again diagnosed with an infection.

Review of the resident's hard copy chart noted a report that the resident was diagnosed with dehydration and an infection and a later report which noted the resident was again diagnosed with two infections.

Review of resident's electronic documentation in Point Click Care (PCC) noted an infection note which indicated the resident had signs and symptoms of an infection and that a sample had been sent for testing.

Review of the resident's weights in PCC noted the resident had lost a significant amount of weight in less than two months, during the time the resident had been noted as having an infection.

Review of resident #001's documented intake of food and fluids on the Documentation Survey Report on PCC noted when the resident was first admitted, the resident ate 75 per cent (%) or more of their meals and consumed their required servings of fluids per day.

The following two months noted a significant decrease in the amount of food the resident was eating and the resident consumed less than their required servings of fluids per day.

Review of the home's "Referral to Dietitian and/or Director of Dietary Services" policy noted in part that the nurse will:
"1) Assess all residents for nutritional risk factors and complete a Dietary Referral (to RD/DDS) if necessary in cases such as:
• Unplanned Weight loss/gain: criteria triggered at 5% change in 30 days, 7.5% change in 90 days, 10% change in 180 days, or undesirable weight change that compromises

resident's health status
• Change in appetite or intake less than 50% for 3 or more days
• Poor fluid intake (less than 6 servings for 3 consecutive days) and exhibits signs and symptoms of dehydration;
• Reassess diet with changes in health status, return from hospital, new diagnosis, new food allergy or intolerance
• New or advanced disease state: cancer, septicemia, liver failure, renal failure, Alzheimer's, depression, GI bleed
• Oral health affecting intake: recent mouth pain, dry mouth, infection or problems with dentition, dental extraction, new/broken/missing dentures
• Chronic UTI, URI requiring antibiotics and treatment."

In an interview, Registered Practical Nurse (RPN) #106 acknowledged that the resident had been diagnosed with dehydration. The RPN confirmed that a referral to the Dietitian had not been submitted for the resident's dehydration or decrease in intake in food and fluids.

In an interview, the Registered Dietitian (RD) stated they had assessed the resident on admission with no concerns. The RD stated at the time of their assessment, the resident was drinking 15 servings of fluid a day and eating 75-100% of their meals.

The RD acknowledged they had received a referral the month after the resident was admitted, related to an abrasion the resident sustained from a fall but they had not been able to enter the home at that time due to COVID so they had not visualized the resident. The RD stated they based their assessment on a record review, that noted the resident's intake had been fluctuating but and at that time the resident's weight was stable.

The RD acknowledged that they had received another referral the following month, which indicated the resident had a loss of appetite and was having chewing issues. The RD stated they had waited nine days to complete the referral, as there were no significant concerns noted in the referral. The RD noted the resident had not been weighed that month and had requested the resident be weighed. The RD stated they also noted at that time the resident's intake was poor with few snacks consumed. The RD stated when they reviewed the resident's fluid intake it was below the resident's required daily fluid intake.

The RD stated when they assessed the resident that compared to when they saw the resident on admission, the resident looked gaunt, physically unwell, lethargic and the RD

stated they could not rouse the resident. The RD stated the resident had visibly lost weight and at that point they ordered a strong supplement for the resident. The RD stated they were so concerned for the resident that they returned to the home two days in a row and sat with the resident to encourage them to eat.

The RD stated they should have received a referral when the resident was diagnosed with dehydration and had an infection. The RD stated they should have received a referral when the resident had a decreased intake of food and fluids and when the resident went from eating independently to needing total assistance.

The licensee has failed to ensure the registered dietitian who was a member of the staff of the home completed a nutritional assessment whenever there was a significant change in resident #001's health condition.[s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1.The licensee has failed to ensure that residents were provided with a range of continence care products based on their individual assessed needs.

A) On July 21, 2020, Complaint #IL-80571-LO was submitted to the Ministry of Long-

Term Care (MLTC) regarding continence care of resident #001.

Under the Required Programs in the Ontario Regulation 79/10 section 48, licensees are required to have a continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.

Review of the home's policy #VII-D-10.20 "Continence Program - Products" current revision April 2019 stated in part,
"Procedure: The Director of Care and/or designate will:
1) Assign one person in the care community as the continence management Lead, who will assume the responsibility to oversee the utilization of continence/incontinence care products.
2)Establish a standing order with the supplier for continence care products after the initial sizing assessment of each resident.
4) Distribute an annual evaluation of effectiveness and satisfaction of continence care products the resident/SDM and direct care team.
6) Ensure that an emergency supply of continence care products is available within the care community".

Review of the home's policy #VII-D-10.00 "Continence Program - Guidelines for Care" current revision April 2019, "Policy: Residents will have an individualized program of continence care developed and documented on the plan of care that directs team members as to the:
-Measures to be taken to promote each resident's normal bowel and bladder function
-Continence care products required to meet the resident's needs for comfort, dignity, and choice.
Procedure: The Nurse will:
1) Upon moving in, annually, and when there is a significant change in condition that impacts
bladder and bowel functioning:
-Obtain information about the resident's bowel and bladder routine
-Identify contributing factors to incontinence
-Reference Bladder and Bowel Assessment
-Implement bowel protocol as per physician's order
2) Complete all documentation regarding resident's level of bladder/bowel continence or incontinence and planned interventions in the appropriate areas of the resident's record such as: Progress Notes, RAI MDS assessments, Annual Reviews, Medication Records, Flow Sheets, and Plan of Care".

A review of resident #001's care plan indicated, in part, under bladder and bowel continence, that the resident required assistance with daily care related to their dementia. The interventions indicated that resident #001 wore TENA (adult briefs) products and directed staff to see the TENA profile for further information.

A review of resident #001’s Kardex for Personal Support Workers (PSWs) indicated, in part for urinary and bowel incontinence, the following:
“See TENA profile for product resident's continence management system is a TENA product. See TENA profile for further information. Please use green brief at HS".

In an interview, PSW #104 was asked how often they toileted resident #001 and they stated after each meal, that it was not written in the care plan but knew that the resident was incontinent.

B) A review of resident #006's care plan indicated the resident was incontinent of bowel and bladder and noted resident #006 wore a TENA product. Staff were directed to see the TENA profile for further information.

C) A review of resident #005’s care plan indicated the resident was incontinent of bowel and bladder and noted resident #005 wore a TENA product. Staff were directed to see the TENA profile for further information.

During interviews Personal Support Workers (PSWs) #103 and #104 both stated that they did not have access to a TENA book, and that there wasn’t one. When asked how they knew what product to use for incontinent residents they stated that this information was shared by other staff, or they asked the resident or put on the same type of product they had just removed.

During an interview with Acting Assistant Director of Care (aADOC) #107 on July 30, 2020, when asked who was in charge of the TENA program, they stated that no one was and that they would take the lead from now on.

During an interview with aADOC #107, they were asked to provide the inspector with the TENA binder containing resident’s assessments for TENA products the residents should be wearing. aADOC #107 could not provide one and stated that they would assess all residents this coming Friday. When asked how staff knew what product to use with a resident that was incontinent, aADOC #107 responded "it's in the care plan". Inspector

#615 mentioned to aADOC #107 that the resident's care plan said to refer to the TENA assessment. When asked if they could provide Inspector #615 the resident's TENA assessments, they could not provide them.

The licensee has failed to ensure that residents #001, #005 and #006 were provided with a range of continence care products based on their individual assessed needs.[s. 51. (2) (h) (i)]

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. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months

Review of the home's "Monitoring Resident Weights" Policy noted in part, that all unplanned weight losses of 5% in 30 days, 7.5 % in 90 days, or 10% in 180 days, and any other weight change that compromises resident's health status, will be assessed and evaluated, and documented and a Registered Dietitian (RD) referral may be required.

In an interview, the Registered Dietitian stated that resident #004 was a high nutritional risk.

Review of the resident's weights in Point Click Care (PCC) noted in June 2019, the resident had a 7.4 percent (%) loss in weight over a one month period and in September 2019 the resident had an 11.1% loss in weight over a four month period.

Review of the resident's electronic progress notes in PCC noted no documentation on the assessment or evaluation of the resident's weight loss as documented in PCC. There were no referrals noted to the RD regarding the resident's weight loss.

In an interview, Registered Practical Nurse (RPN) #106 reviewed the resident's weights in PCC. The RPN acknowledged that there had been no referrals to the RD in June and September 2019, when the resident lost weight. The RPN stated there should have been an assessment regarding the resident's weight loss and a referral to the RD.

In an interview, the Director of Care (DOC) stated registered staff should monitor a resident who had a weight loss and refer the resident to the Dietitian and investigate if something was going on with the resident.

The licensee has failed to ensure that resident #004, who had a 5% weight loss in one month and a 10% weight loss in four months was assessed using an interdisciplinary approach. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months, to be implemented voluntarily.

Issued on this 23rd 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), HELENE DESABRAIS (615)
Inspection No. / No de l'inspection :	2020_725522_0003
Log No. / No de registre :	012700-20, 013158-20, 013561-20, 014915-20
Type of Inspection / Genre d'inspection:	Complaint
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

Ordre(s) de l'inspecteur

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

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

Order / Ordre :

The licensee must comply with s. 6. (10) (b) of the LTCHA.

Specifically, the licensee must ensure that resident #001 and all other residents with suspected urinary tract infections are reassessed and their plan of care reviewed and revised in order for residents to receive treatment in a timely manner.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Two complaints were received by the Ministry of Long-Term Care related to concerns of improper care provided to resident #001.

In an interview, the resident's Power of Attorney (POA) stated they had concerns regarding the care the resident had received since their admission to the home.

The complainant stated the resident had a significant weight loss, had declined, was very weak, had several falls and that it had taken two weeks for the resident to receive antibiotics for an infection.

The complainant stated on one occasion they insisted the resident be sent to hospital and the resident was diagnosed with dehydration and an infection. The complainant stated on another occasion they took the resident to hospital themselves where the resident was again diagnosed with an infection.

Review of the resident's admission care plan noted the resident required set up only for eating, one team member assistance for toileting and one person assist for walking and locomotion.

Review of the resident's most recent care plan noted the resident required total assistance of one team member for meals, one to two staff assistance for toileting. The resident required one to two staff assistance with locomotion or use of an assistive device with one staff assistance and that the resident was a one to two person transfer.

Review of resident #001's electronic progress notes in Point Click Care (PCC) noted the resident had four falls within eight days. After the fourth fall a sample had been sent to the lab for the resident as staff had suspected the resident had an infection.

Four days after the sample was sent, results revealed the sample had been contaminated and another sample was sent three days after the home was notified.

After the second sample was sent the resident was noted to have increased confusion and had three more falls.

There was no documentation to support that that the POA's request to send the resident to hospital to be tested for an infection and started on antibiotics was discussed with the resident's physician, nor was it discussed with the oncall physician. There was no documentation to support that either physician was made aware of the number of falls the resident had up to and since the resident had a sample sent to determine if the resident had an infection.

Eleven days after the first sample was sent to determine if the resident had an infection, the resident was started on antibiotics. The resident had another fall

the next day.
Seven days after the resident had started on antibiotics, progress notes indicated the resident was drowsy and weak and the family had expressed concerns that the resident could not speak on the phone.

The Director of Care (DOC) stated in the resident's progress notes that they had spoken to the resident's POA about the resident's dementia process and that the resident's treatment had just finished for an infection. The POA had questioned whether the resident may have had a stroke and DOC indicated that the resident did not have a stroke. The POA requested that the resident be transferred to the hospital for further medical assessment. The DOC contacted the resident's physician and the resident was sent to hospital where the resident was diagnosed with dehydration and an infection.

Two days later progress notes indicated the resident was more alert, bright and talking to staff. The resident was required to be fed by staff and staff encouraged fluid intake.

Progress notes indicated nine days after the resident had been seen at the hospital, the resident had been eating less than half of their meals. The notes indicated the resident was drowsy, very weak and had no energy.

The resident's POA had taken the resident out for an appointment and took the resident to the hospital where the resident was diagnosed with two infections and started on antibiotics.

During two separate interviews, Registered Practical Nurse (RPN) #106 stated resident #001 had quite a few falls and they had called the resident's physician to get a sample to send to determine if the resident had an infection. The RPN stated the resident did not have any falls since they began treatment for the infection.

The RPN stated the resident had difficulty with eating and drinking and needed a lot of encouragement and they were monitoring the resident's food and fluid intake. The RPN stated the resident was independent with eating and were ambulatory when they were first admitted and when the resident started to decline, they required total assistance with feeding, which they still received and

now used a an assistive device. The RPN stated that the resident had lost a significant amount of weight since they were admitted which the RPN attributed to fluid loss.

The RPN stated there had been no discussion with staff and management about sending the resident to the hospital. The RPN stated they had spoken with the resident's POA who requested that the resident be sent to hospital to be tested for an infection. The RPN stated they had left a note in the registered staff day planner for staff to follow up with the resident's physician. The RPN reviewed the schedule and noted an agency staff member had worked that day and did not follow up with the resident's physician.

In an interview, the resident's Physician stated they had started the resident on a mild opioid and they did not think it would cause significant lethargy. The Physician stated they had never observed the resident in a state of confusion or difficult to rouse. The Physician stated they did not feel the significant change in the resident's status was related to their dementia process as the resident always addressed the Physician appropriately.

When asked about the two week delay in the resident receiving antibiotic therapy, the Physician stated they liked to see the test result before giving an antibiotic but if they had of been made aware that the resident had several falls while waiting for the test results they would have expected that the resident was sent to hospital to be tested.

During two separate interviews, the Director of Care (DOC) acknowledged that they had spoken to the resident's POA. The DOC stated they were aware staff had sent a sample to be tested for the resident as the resident's status had changed. The DOC stated they were aware of the length of time it had taken to get the test results and they had called the lab. When the Inspector asked the DOC if they were concerned regarding the number of falls the resident had while waiting to start antibiotics, the DOC stated the resident was a high risk for falls and they could not prevent the resident from falling just put interventions in place to prevent injury. When asked by the Inspector why resident had not been sent to hospital to be tested due to their falls and change in condition, the DOC stated they did everything the resident needed after their falls and put interventions in place.

The DOC stated when the resident's POA brought forward concerns regarding the resident's decline and wanted the resident to be sent to hospital, they told the POA the resident's decline was part of the resident's dementia process. When the Inspector asked the DOC if during that time they had physically assessed the resident, the DOC stated they did not assess the resident. The DOC acknowledged that the resident was sent to the hospital after the discussion with the resident's POA and diagnosed with an infection and dehydration.

The licensee has failed to ensure that resident #001 was reassessed and their plan of care reviewed and revised when the resident's care needs changed.

The severity of this issue was determined to be a level 3 as there was actual harm. 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:
• Compliance Order issued October 2, 2019 (2019_725522_0013);
• Voluntary Plan of Correction issued March 13, 2019 (2019_605213_0009).
(522)

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

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. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3).
O. Reg. 79/10, s. 26 (4).

Order / Ordre :

The licensee must comply with s. 26 (4) of Ontario Regulation 79/10.

Specifically, the licensee must ensure that resident #001 and all other residents are assessed by a registered dietician whenever there is a significant change in the resident's health condition.

Grounds / Motifs :

1. The has licensee failed to ensure the registered dietitian who was a member of the staff of the home completed a nutritional assessment whenever there was a significant change in the resident's health condition.

Two complaints were received by the Ministry of Long-Term Care related to concerns of improper care provided to resident #001.

In an interview, the resident's Power of Attorney (POA) stated they had concerns regarding the care the resident had received since their admission to the home.

The complainant stated the resident had a significant weight loss, had declined, was very weak, had several falls and that it had taken two weeks for the resident to receive antibiotics for an infection.

The complainant stated on one occasion they insisted the resident be sent to hospital and the resident was diagnosed with dehydration and an infection. The

complainant stated on another occasion they took the resident to hospital themselves where the resident was again diagnosed with an infection.

Review of the resident's hard copy chart noted a report that the resident was diagnosed with dehydration and an infection and a later report which noted the resident was again diagnosed with two infections.

Review of resident's electronic documentation in Point Click Care (PCC) noted an infection note which indicated the resident had signs and symptoms of an infection and that a sample had been sent for testing.

Review of the resident's weights in PCC noted the resident had lost a significant amount of weight in less than two months, during the time the resident had been noted as having an infection.

Review of resident #001's documented intake of food and fluids on the Documentation Survey Report on PCC noted when the resident was first admitted, the resident ate 75 per cent (%) or more of their meals and consumed their required servings of fluids per day.

The following two months noted a significant decrease in the amount of food the resident was eating and the resident consumed less than their required servings of fluids per day.

Review of the home's "Referral to Dietitian and/or Director of Dietary Services" policy noted in part that the nurse will:
"1) Assess all residents for nutritional risk factors and complete a Dietary Referral (to RD/DDS) if necessary in cases such as:
• Unplanned Weight loss/gain: criteria triggered at 5% change in 30 days, 7.5% change in 90 days, 10% change in 180 days, or undesirable weight change that compromises resident's health status
• Change in appetite or intake less than 50% for 3 or more days
• Poor fluid intake (less than 6 servings for 3 consecutive days) and exhibits signs and symptoms of dehydration;
• Reassess diet with changes in health status, return from hospital, new diagnosis, new food allergy or intolerance
• New or advanced disease state: cancer, septicemia, liver failure, renal failure,

Alzheimer's, depression, GI bleed
• Oral health affecting intake: recent mouth pain, dry mouth, infection or problems with dentition, dental extraction, new/broken/missing dentures
• Chronic UTI, URI requiring antibiotics and treatment."

In an interview, Registered Practical Nurse (RPN) #106 acknowledged that the resident had been diagnosed with dehydration. The RPN confirmed that a referral to the Dietitian had not been submitted for the resident's dehydration or decrease in intake in food and fluids.

In an interview, the Registered Dietitian (RD) stated they had assessed the resident on admission with no concerns. The RD stated at the time of their assessment, the resident was drinking 15 servings of fluid a day and eating 75-100% of their meals.

The RD acknowledged they had received a referral the month after the resident was admitted, related to an abrasion the resident sustained from a fall but they had not been able to enter the home at that time due to COVID so they had not visualized the resident. The RD stated they based their assessment on a record review, that noted the resident's intake had been fluctuating but and at that time the resident's weight was stable.

The RD acknowledged that they had received another referral the following month, which indicated the resident had a loss of appetite and was having chewing issues. The RD stated they had waited nine days to complete the referral, as there were no significant concerns noted in the referral. The RD noted the resident had not been weighed that month and had requested the resident be weighed. The RD stated they also noted at that time the resident's intake was poor with few snacks consumed. The RD stated when they reviewed the resident's fluid intake it was below the resident's required daily fluid intake.

The RD stated when they assessed the resident that compared to when they saw the resident on admission, the resident looked gaunt, physically unwell, lethargic and the RD stated they could not rouse the resident. The RD stated the resident had visibly lost weight and at that point they ordered a strong supplement for the resident. The RD stated they were so concerned for the resident that they returned to the home two days in a row and sat with the

resident to encourage them to eat.

The RD stated they should have received a referral when the resident was diagnosed with dehydration and had an infection. The RD stated they should have received a referral when the resident had a decreased intake of food and fluids and when the resident went from eating independently to needing total assistance.

The licensee has failed to ensure the registered dietitian who was a member of the staff of the home completed a nutritional assessment whenever there was a significant change in resident #001's health condition

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was level 1 as it was isolated, involving one out of three residents. The home has a level 2 compliance history as there was previous non-compliance to a different subsection of the Regulations. (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 :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee must comply with s. 51. (2) (h) (i) of Ontario Regulation 79/10.

Specifically, the licensee must ensure that residents #001, #005 and #006 and all other residents that require continence care products are assessed and provided continence care products based on their individual assessed needs.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were provided with a range of continence care products based on their individual assessed needs.

A) On July 21, 2020, Complaint #IL-80571-LO was submitted to the Ministry of Long-Term Care (MLTC) regarding continence care of resident #001.

Under the Required Programs in the Ontario Regulation 79/10 section 48, licensees are required to have a continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.

Review of the home's policy #VII-D-10.20 "Continence Program - Products" current revision April 2019 stated in part,
"Procedure: The Director of Care and/or designate will:
1) Assign one person in the care community as the continence management Lead, who will assume the responsibility to oversee the utilization of continence/incontinence care products.
2)Establish a standing order with the supplier for continence care products after the initial sizing assessment of each resident.
4) Distribute an annual evaluation of effectiveness and satisfaction of continence care products the resident/SDM and direct care team.
6) Ensure that an emergency supply of continence care products is available within the care community".

Review of the home's policy #VII-D-10.00 "Continence Program - Guidelines for Care" current revision April 2019, "Policy: Residents will have an individualized program of continence care developed and documented on the plan of care that directs team members as to the:
-Measures to be taken to promote each resident's normal bowel and bladder function

-Continence care products required to meet the resident's needs for comfort, dignity, and choice.
Procedure: The Nurse will:
1) Upon moving in, annually, and when there is a significant change in condition that impacts
bladder and bowel functioning:
-Obtain information about the resident's bowel and bladder routine
-Identify contributing factors to incontinence
-Reference Bladder and Bowel Assessment
-Implement bowel protocol as per physician's order
2) Complete all documentation regarding resident's level of bladder/bowel continence or
incontinence and planned interventions in the appropriate areas of the resident's record such as: Progress Notes, RAI MDS assessments, Annual Reviews, Medication Records, Flow Sheets, and Plan of Care".

A review of resident #001's care plan indicated, in part, under bladder and bowel continence, that the resident required assistance with daily care related to their dementia. The interventions indicated that resident #001 wore TENA (adult briefs) products and directed staff to see the TENA profile for further information.

A review of resident #001's Kardex for Personal Support Workers (PSWs) indicated, in part for urinary and bowel incontinence, the following: "See TENA profile for product resident's continence management system is a TENA product. See TENA profile for further information. Please use green brief at HS".

In an interview, PSW #104 was asked how often they toileted resident #001 and they stated after each meal, that it was not written in the care plan but knew that the resident was incontinent.

B) A review of resident #006's care plan indicated the resident was incontinent of bowel and bladder and noted resident #006 wore a TENA product. Staff were directed to see the TENA profile for further information.

C) A review of resident #005's care plan indicated the resident was incontinent of bowel and bladder and noted resident #005 wore a TENA product. Staff were directed to see the TENA profile for further information.

During interviews Personal Support Workers (PSWs) #103 and #104 both stated that they did not have access to a TENA book, and that there wasn't one. When asked how they knew what product to use for incontinent residents they stated that this information was shared by other staff, or they asked the resident or put on the same type of product they had just removed.

During an interview with Acting Assistant Director of Care (aADOC) #107 on July 30, 2020, when asked who was in charge of the TENA program, they stated that no one was and that they would take the lead from now on.

During an interview with aADOC #107, they were asked to provide the inspector with the TENA binder containing resident's assessments for TENA products the residents should be wearing. aADOC #107 could not provide one and stated that they would assess all residents this coming Friday. When asked how staff knew what product to use with a resident that was incontinent, aADOC #107 responded "it's in the care plan". Inspector #615 mentioned to aADOC #107 that the resident's care plan said to refer to the TENA assessment. When asked if they could provide Inspector #615 the resident's TENA assessments, they could not provide them.

The licensee has failed to ensure that residents #001, #005 and #006 were provided with a range of continence care products based on their individual assessed needs.

The severity of this issue was determined to be a level 2 as there was minimal risk to residents. The scope of the issue was level 3 as it was widespread, involving three out of three residents. The home has a level 1 compliance history as there was no previous non-compliance to this section of the Regulations. (615)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2020

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:

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

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