Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 13, 2018	2018_740621_0015	008769-18	Resident Quality Inspection

Licensee/Titulaire de permis

Board of Management of the District of Kenora
1220 Valley Drive KENORA ON P9N 2W7

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

Pinecrest (Kenora)
1220 Valley Drive KENORA ON P9N 2W7

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

JULIE KUORIKOSKI (621), DEBBIE WARPULA (577), MELISSA HAMILTON (693), SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 28 - June 1 and June 4 - 8, 2018.

- One Critical Incident (CI), related to wound management, continence care and bowel management, medication management, and personal support services;
- One CI related to falls prevention and management;
- One Complaint related to a resident fall with injury;
- One Complaint related to staffing, plan of care, personal support services, dining and snack service, and continence care;
- One Complaint related to staffing, personal support services, and weight management;
- One Complaint related to housekeeping, weight management and personal support services; and
- One Complaint related to therapy services, plan of care, medication management, infection control, personal support services, responsive behaviours, continence care, dining and snack service, weight management, resident bill of rights, staff training, and alleged staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Acting Director of Care (ADOC), Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Resident Assessment Instrument (RAI) Coordinator, Physiotherapist (PT), Registered Dietitian (RD), Food Services Supervisor (FSS), a Dietary Aide, a Cook, the Environmental Services Manager (ESM), Support Services Engineer, Housekeeping Aides, the Resident Activation Coordinator, Manager of Dental Services, residents and family members.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident, and resident to resident interactions, reviewed relevant health records, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing
Training and Orientation

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

- **19 WN(s)**
- **15 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Ontario Regulation 79/10, s.100 requires that the licensee ensure that written procedures under section 21 of the Act incorporates the requirements set out in section 101.

A complaint was received by the Director alleging improper care of resident #001 by home's staff.

During an interview with the complainant, they reported to Inspector #621 that in early 2018, a written letter of complaint was provided to the home which outlined their concerns with regards to resident #001's care.

During an interview with the Administrator, they reported to Inspector #621 that they had received a letter of complainant in early 2018, which they provided a written response to the next day.

On review of the letter of complaint faxed to the home on a specified day in early 2018, it was alleged that resident #001's care needs had not been met; identifying that home's staff had not completed a particular activity properly with the resident, which resulted in a negative health outcome.

On review of the letter of response from the Administrator on a specified day in early 2018, it was identified that there was no response to specific allegations outlined in the letter of complaint.

Inspector #621 reviewed the home's policy titled "Managing and Reporting Complaints - ADM 415", last revised in May 2014, which identified that anyone could register a complaint about potential or witnessed abuse and/or neglect, such as, improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident. Additionally, the policy identified that all complaints alleging potential abuse and/or neglect were to be immediately reported via the Critical Incident System (CIS) to the Director according to mandatory reporting requirements, and investigated. Further, the policy indicated that the home was to provide a follow up response to the complainant, indicating what the home did to resolve the complaint, or that the home

believed the complaint to be unfounded, and the reasons for that belief. As well, the policy outlined that the home was to keep a documented record of all written complaints, which included: the nature of the complaint and date received; actions taken including date of actions, time frames for investigation, actions towards resolution, response to the complainant and follow up actions; final resolution, dates and description of response; a copy of the written complaint forwarded to the Ministry of Health and Long-Term Care; and responses made to the complainant.

During a subsequent interview with the Administrator, they confirmed to Inspector #621 that the letter of complaint had alleged improper or incompetent care of resident #001 resulting in a negative health outcome; and that they had not reported the allegation immediately to the Director. As a consequence, an investigation into the allegation did not occur, nor was documentation completed, or a response to the complainant provided with regards to the outcome of an investigation into their complaint. Further, the Administrator confirmed that the oversight resulted in the home not having complied with their policy on managing and reporting complaints. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or the Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, that the policy was complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

On a specific day in June 2018, Inspector #621 observed a particular lounge area in the home, which had a specified number of high back chairs with multiple stains embedded into their green fabric backrests.

Additionally, the Inspector observed another particular lounge area in the home, with a specified number of the same high back chairs, again with multiple stains on their fabric backrests.

During an interview with Housekeeping Aide #125, they reported to Inspector #621 that as part of their housekeeping duties for a particular home area, they completed a daily wipe down of chairs in the lounge areas; performed a more thorough cleaning of the lounge areas once a month; and, if at any time furnishings were observed to be heavily soiled or stained, they would remove the furniture from the unit to wash with the mechanical washer. Additionally, Housekeeping Aide #125 identified that housekeeping staff tracked cleaning on a monthly schedule for each unit, and that the lounge areas had a deeper cleaning completed during one week of each month.

Inspector #621 reviewed the housekeeping schedules for the identified home area, for April and May 2018, which identified that monthly cleaning of one particular lounge area had been completed during the weeks of April 30 - May 4, 2018 and May 28 - June 1, 2018. Additionally, monthly cleaning of the other particular lounge area was documented to have been completed during the weeks of April 23 - 27, 2018 and May 21 - 25, 2018.

During an interview with the Environmental Services Manager (ESM), they reported to Inspector #621 that housekeeping staff assigned to each unit had a four week cleaning schedule which outlined cleaning details, with staff expected to sign off when required cleaning on each unit was completed.

Additionally, the ESM identified that housekeeping staff were to return the completed cleaning schedules to them after each month for archiving. The ESM confirmed to the Inspector that housekeeping staff had signed off both the April and May 2018 housekeeping schedules to indicate that cleaning of the lounge areas had been completed.

Together with Inspector #621, Housekeeping Aide #125 and the ESM observed the specific number of green colored high back chairs from both lounge areas in the specific home area, and confirmed that all had deep stains embedded into the fabric of each backrest, and that the chairs were not maintained in a clean and sanitary condition. Additionally, Housekeeping Aide #125 identified to the Inspector that the chairs had been in that condition for a number of months. [s. 15. (2) (a)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that harm or risk of harm to a resident occurred, or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A complaint was received by the Director alleging improper care of resident #001 by home's staff.

On review of a letter from the complainant's legal representative, it was alleged that there had been multiple incidents which demonstrated that resident #001's care needs were not being met, which resulted in a negative health outcome.

During an interview with the Administrator, they confirmed to Inspector #621 that the letter from the complainant's legal representative on a specific day in January 2018, alleged improper or incompetent care of resident #001, and that the home had not reported the allegation of potential neglect immediately to the Director.

Refer to WN #1, finding 1, for further details. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that harm or risk of harm to a resident occurred, or may occur, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A complaint was submitted to the Director on a day in January 2018, which alleged certain care was not provided to residents on a specific nursing unit when they were short staffed of PSWs.

A review of the home's staffing plan provided by the DOC indicated that a specific nursing unit in the home, on any given evening shift was to be staffed with an RN that covered the identified unit and one other; an RPN; and three PSWs (one of which was a short shift).

On a specific day in June 2018, Inspector #617 observed that the nursing unit in question was short one PSW who was scheduled to work the short shift, leaving PSWs #116 and

#117 to provide resident care during the entire evening shift for a specific number of residents.

A review of the resident bath list located at the nursing station indicated that the two PSWs were required on the evening shift to: complete a specific number of resident scheduled baths; porter residents to the dining room located off unit; serve and assist residents with their dinner meals; and deliver snack pass to residents. A review of the resident's care plans indicated that a specified number of residents required a specific type of care activity at a certain time, and all residents required assistance with another particular type of care activity.

Inspector #617 observed PSWs #116 and #117 working together to provide a specific type of care activity to certain residents; RN #118 was observed providing other specific types of care activities to residents; and RPN #141 was observed completing a certain activity with residents, which by a specified time, had not been completed.

During an interview with PSW #116, they confirmed to Inspector #617 that they had a specific number of residents scheduled for a specific care activity during a specific shift in June 2018, and that they had not been able to complete the specific care activity with a resident #027 due to working short, and resident #027's care would be made up on the next scheduled shift.

A review of resident #027's most current care plan, dated from May 2018, indicated that they required a certain type of assistance with the specified care activity and were to receive this type of care at scheduled times of the week.

At a specific time on a certain day in June 2018, Inspector #617 interviewed resident #027 who confirmed that staff had not completed a specific care activity with them up to that point on the shift.

Inspector #617 reviewed the home's records for all specified residents that were scheduled for a particular care activity to be done with them on that shift in June 2018. The Inspector identified that the specific care documentation for resident #027 was missing.

During interviews on another day in June 2018, PSWs #121 and #123 reported to Inspector #617 that they were not aware that a shift from the previous day had worked short, and were not aware that resident #027 had missed a specific type of care. PSW

#123 reviewed the PSW documentation for resident #027 and confirmed that information on the record was missing and the PSW staff had not signed off that the care activity had been completed with this resident. PSW #123 further explained that the resident must not have had the specific type of care completed during the particular shift on a the specified day in June 2018, as there was no communication on shift change for staff to make up the missed care.

A review of the homes PSW staffing shortages for the specific nursing unit, indicated the following:
- Over a three week period during March 2018, there were a total of four shifts where the unit worked one PSW short;
- For April 2018, one shift was identified where the unit worked one PSW short; and
- During May 2018, one shift was identified where the unit worked one PSW short, and another shift where the unit worked two PSWs short.

During a review of the home's policy titled, "Staffing Plan - #ADM 235", last revised in September 2014, Inspector #617 identified that the home's staffing plan did not identify that an evaluation of the changing needs of the residents was completed, or what changes to the staffing complement would occur to accommodate the residents changing needs. Additionally, the plan did not indicate what strategies staff were to be implemented when working short, and how missed care was to be communicated and accomplished across shifts.

During an interview with the DOC, they reported to Inspector #617 that the home had not kept a written record of the home's staffing plan evaluation. The DOC further explained that they had just started a focus group with the nursing staff to review the lack of communication between shifts and were in the process of creating a reporting structure for the team to determine missed resident care, as well as a plan to provide the care. Additionally, the DOC reported that they had determined that certain units had experienced changes to the residents' care needs and that it would be addressed in the focus group to ensure that the appropriate amount of nursing staff was provided to meet the changing needs of the residents. [s. 31. (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 a written record is kept relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The Licensee has failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of residents.

A complaint was received by the Director on a day in January 2018, which reported that on a specific nursing unit in the home, residents were being left for up for a specific period of time before unit staff assisted them with a specific type of care.

On a specific day in May 2018, Inspector #617 observed a specified number of residents on the specified nursing unit; sitting in their mobility aides and situated in a certain location of the unit. In an interview with the RN #118, they explained that the residents were waiting to have a particular type of care completed in a certain area of the unit, as they required assistance from staff and that they personal rooms were not accommodating. RN #118 reported that there were a specific number of residents on that unit which required a particular care activity completed with a specified number of staff, in a specific location, on the unit.

During an interview with resident #023 on a specific day in May 2018, they reported to the Inspector that they required the assistance of staff with a particular care activity.

Additionally, resident #023 stated that they would wait for a specific amount of time to have a certain care activity completed, as their own room was not able to accommodate their mobility aide during the activity.

On a specific day and time in June 2018, Inspector #617 observed resident #023 activate their communication device. In an interview with the resident they reported to the Inspector that they had been waiting since a particular time to have a certain care activity provided and were frustrated they had to wait. Then at a specific time later, the Inspector observed PSWs #116 and #117 take the resident to complete the care activity in a certain location of the unit.

On another specific day and time in June 2018, Inspector #617 observed resident #023 located in a certain area of the unit in their mobility aide. The resident was interviewed and they reported to the Inspector that they had been waiting for a certain period of time to have a specific care activity completed. In addition to resident #023, there was another resident waiting in specific care of the unit with them. Resident #023 expressed frustration that they had to wait to have a certain care activity completed. At a specific time later, Inspector #617 observed PSWs #120 and #104 bring resident #023 to a certain location of the unit to complete the identified care activity.

A review of resident #023's care plan dated from May 2018, indicated that resident #023 required a certain level and type of care assistance from staff, on an as needed basis. The care plan also identified that the resident used a mobility aide for locomotion.

During interviews with RN #118 and PSW #117, they reported to Inspector #617 that resident #023 required assistance of a specified number of staff to complete a care activity; routinely required this care activity completed after another specified activity was completed; and at times required the use of an assistive device to complete the activity. RN #118 explained that a particular area of the resident’s room did not safely accommodate the resident, staff, and the presence of a mobility aide or assistive device. As a result, the staff provided assistance with a certain care activity in a particular location of the unit, as this location had space to safely accommodate residents who required this type and level of assistance.

On June 8, 2018, Inspector #617 completed measurements of a certain location of resident #023's room and found that there was inadequate space to maneuver the resident, their mobility aide, as well as staff be present to provide assistance at the same time.

Inspector #617 interviewed the Administrator, who reported that the nursing unit area in question was part of the building's old infrastructure and that certain areas of resident rooms were narrow. The Administrator indicated that they were not aware that there were residents who were waiting for long periods of time to be assisted with a certain care activity in a particular location on the unit. The Administrator discussed possible options to enable resident rooms to accommodate a certain care activity. [s. 44.]

2. At a specific time, on a certain date in June 2018, Inspector #617 observed resident #025 and one other resident sitting with their mobility aides in a certain area of the unit. The Inspector interviewed resident #025, who reported that they had been waiting for a specific amount of time to obtain staff assistance with a particular care activity. At a another specific time, the Inspector observed PSWs #122 and #110 take resident #025 to a certain location of the unit to complete the care.

A review of resident #025's care plan dated from April 2018, indicated that the resident required staff assistance with a particular care activity at a certain time.

Inspector #617 interviewed PSWs #110 and #136, who both reported that resident #025 required the use of an assistive device with staff assistance with a specified type of care activity. PSW #110 also reported that the resident was routinely assisted with the care activity at a particular time. PSW #136 additionally reported that a specific location in the resident's room could not accommodate the resident, their mobility aide and a particular number of staff to be present at the same time. As a result, PSW #136 reported that the resident received the specified type of care in another location of the unit, as there was enough space, and it was equipped with a specific type of assistive device. PSW #110 further explained to the Inspector, that resident #025 had to wait for staff to assist them with the particular care activity as there were many other residents on the unit who also had the same care need.

On the same day in June 2018, Inspector observed a particular area of resident #025's room and identified that the area could not accommodate a certain type of assistive device, and measured the dimensions of the specific area. From this, it was determined that the area was too narrow to accommodate a mobility aide, and a particular number of staff at the same time to provide the required care of this resident. [s. 44.]

3. On another day, at a specified time, in June 2018, Inspector #617 observed resident #024 sitting in their room, with their mobility aide, and call for assistance. At that time,

resident #024 reported to the Inspector that they needed assistance with a particular care activity and had been waiting since a specified time for staff to assist them. At a specific time later, PSWs #116 and #117 were observed by the Inspector to enter the resident's room and proceed to assist the resident with the identified care activity.

A review of resident #024's care plan dated from May 2018, indicated that the resident required a certain amount of assistance, from a specified number of staff, using an assistive device to complete a certain type of care activity. Inspector #617 interviewed PSW #116 who confirmed the resident's report of their particular care needs. PSW #116 explained that the resident's room was not equipped with a certain assistive device to complete the care activity in that area, and as a result, required the care to be completed in another specific area of the unit. PSW #116 further reported that the resident was among other residents who also required a specific number of staff, and use of a certain type of assistive device, in order to complete their care. As a consequence, PSW #116 reported that there was a wait time for the resident to have their care activity completed.

On the same day in June 2018, the Inspector observed a specific area of resident #024's room and measured its dimensions. From this, the Inspector determined that there was insufficient area with which to accommodate a particular number of staff, the resident, as well as their mobility aide to be present during a certain care activity. [s. 44.]

4. During a specific day and time in June 2018, Inspector #617 observed resident #026 sitting with their mobility aide in the particular area of the unit. In an interview with resident #026, they reported to the Inspector that they were anxious to get assistance with a certain care activity and had been waiting a long time. At a specified time later, the Inspector observed PSWs #110 and #121 take resident #026 to complete their care. Later that same day at another specified time, Inspector #617 observed resident #026 sitting at a particular area of the unit. The resident was upset, and stated to the Inspector that they had been waiting for a long time for staff to assist them with the certain care activity. At another specified time later, the Inspector observed resident#026 being assisted by PSWs #116 and #117 to complete the care.

A review of resident #026's care plan dated from May 2018, indicated that they required the assistance of a particular number of staff and required use of a certain assistive device to complete a specific care activity. Inspector #617 interviewed PSW #117, who confirmed that resident #026 required specific staff assistance and an assistive device to complete the specified care. PSW #117 also reported that a specific area of the resident's room could not accommodate the required assistive device, and as a result,

the resident required the use another specific area of the unit to complete their care. Additionally, PSW #117 indicated that the resident was routinely assisted at a particular time of the day meal, and would be required to wait for staff assistance, as there were several residents on the unit who required the same type of assistance. Finally, PSW #117 identified that the resident had responsive behaviours, which could be triggered when they had to wait.

On the same day in June 2018, Inspector #617 observed a specific area in resident #026's room, which when measured had only a specified dimension. As a consequence, it was identified by the Inspector that there was insufficient space in specified area of resident #026's room to complete the particular type of care this resident required. [s. 44.]

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 supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a falls prevention and management program of the home was developed and implemented in the home.

A complaint was received by the Director on a day in April 2018, which alleged concerns with resident #002's care, indicating that the resident had a specific number of falls, and that the final fall which occurred on a specific day in April 2018, resulted in injury. The report further indicated that the resident was left alone during a specific care activity when they fell.

A Critical Incident System (CIS) report was received by the Director on a specific day in April 2018, which indicated that resident #002 fell while being left unattended to complete a certain care activity, which resulted in injury.

A review of resident #002's health record, including their falls care plan interventions, indicated that the resident was not to be left unattended when completing a specified type of care. During a review of resident #002's progress notes dated from a specific day in April 2018, Inspector #577 identified that RPN #134 had assisted resident #002 with their care, but left the resident to complete another activity, and during that time the resident fell. Documentation further indicated that the resident was transferred to an acute care facility and later diagnosed with a specific type of injury.

During an interview with RN #119, they reported to Inspector #577 that resident #002

was a fall risk; and the most recent fall occurring when the resident was left unattended during the specified care activity. RN #119 further reported that the resident's care plan indicated that the resident was not to be left alone. Additionally, during an interview with PSW #135, they reported that resident #002 was a fall risk and staff could not leave the resident unattended during specific care.

Inspector #577 conducted a review of the Fall's Program, titled "Falls Prevention Program – NUR 145", last revised May 2017; which indicated that post-fall, the registrant was to complete an incident investigation Goldcare progress note/PN-IF. Subsequently, a review of the PN-IF incident report was to occur and fall prevention interventions implemented, and modifications to the plan of care were to occur in collaboration with the interdisciplinary team. As well, the document indicated that communication to all shifts was to occur detailing the interventions initiated.

During an interview with the DOC, they confirmed to Inspector #577 that the resident was left unattended during the specified care activity, which resulted in a fall. The DOC further confirmed that the care plan intervention, which instructed staff to not leave the resident unattended during the care activity was initiated after their first fall, and that resident #002's care plan had not been followed. [s. 48. (1) 1.]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's #002, #003 and #004 had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

a) A complaint was received by the Director on a day in April 2018, which alleged concerns regarding resident #002's care, citing a particular number of previous falls, as well as another fall on a specific day in April 2018, which resulted in injury of resident #002.

A Critical Incident System (CIS) report was received by the Director on a day in April 2018, which indicated that resident #002 had fallen in a particular location while they were left unattended to complete a certain care activity. The report further indicated that resident #002 suffered an injury as a result of the fall.

During a review of resident #002's health record, including progress notes dated from April 24, 2018, Inspector #577 identified that RPN #134 had assisted resident #002 initially with their care; but then left the resident unattended in order to complete another activity, and during that time, the resident fell. The progress notes further indicated that the resident was transferred to an acute care facility and was later diagnosed with a specific type of injury.

During a record review of resident #002's falls care plan interventions, it was identified by Inspector #577 that the resident was not to be left unattended for the specified care activity.

Inspector #577 reviewed resident #002's health records, including the "Progress Note - Incident of Fall" (PNIF) section of the Goldcare progress notes, which indicated that the resident fell on a specific date and time in April 2018, while being left unattended during a

specific care activity. On further review of the PNIF, Inspector #577 found no information that determined the resident's fall risk score or reassessment of the resident.

b) During Stage one of the inspection, resident #003 was identified to have had a fall.

A review of resident #003's care plan identified that the resident at risk of injury from falls.

Inspector #577 reviewed resident #003's health records, including the PNIF section of the Goldcare progress notes, which indicated that the resident had a fall on a specific date and time in May 2018, in a certain location of the unit. It was identified that resident #003 was transferred to the hospital. On further review of the PNIF, Inspector #577 found no information that determined the falls risk score or reassessment of the resident.

c) During Stage one of the inspection, resident #004 was identified as having had a fall.

A review of resident #004's care plan identified that the resident had a history of falls and was at risk of injury from falls.

A review of the Goldcare progress note PNIF for resident #004 indicated that the resident had a fall on a certain date and time in May 2018, and sustained an injury. A review of the Goldcare PNIF did not provide a falls risk score or reassessment of the resident.

During an interview with RN #119, they reported to Inspector #577 that a Goldcare PNIF progress note was done after every fall. RN #119 further reported that registered staff would also perform a head to toe and range of motion assessment, take the resident's vital signs, and notify the family and physician of any injuries.

A review of the home's policy titled "Falls Prevention Program - NUR 145", last revised May 2017, indicated that staff were required to complete an assessment of a resident post fall, which included an incident investigation in the Goldcare progress notes section "PN-IF Incident of Fall", including all contributing factors.

During an interview with the ADOC, they reported to Inspector #577 that the Goldcare progress notes section PNIF was considered the home's clinical post fall assessment and was completed after every fall. On further discussion with the Inspector, the ADOC confirmed that the home did not have assessment and reassessment instruments within the home's Falls Prevention and Management Program. [s. 49. (2)] (577)

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 when a resident has fallen, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #8: 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 any other weight change that compromised their health status, were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated.

Resident #005 was identified to have had a weight change.

Inspector #577 conducted a record review of resident #005's weight history over a specific period of time and found that the resident had a certain amount of weight change. The Inspector also found no recorded weight for one particular month in each of 2017 and 2018.

During a review of resident #005's health record, including progress notes during a specific time frame in 2018, Inspector #577 found no documentation which identified that a referral had been made to the Registered Dietitian (RD) for the weight change, or that the RD had been made aware, and that a subsequent assessment had been completed to address the weight change. The most current nutrition review following recorded weight loss in March 2018 was completed on a specified date in late April 2018.

A record review of the home's policy titled "Weighing Residents - NUR 405", last revised October 2014, identified that the registrant would transfer residents monthly weights into the "Vital Signs" section of the electronic health record on the day they were taken, and that weight changes were automatically calculated, and the RD automatically informed.

During an interview with the RD, they confirmed with Inspector #577 that resident #005 had a significant weight change over a specific period of time in the winter of 2018. They further reported, that there had been weight discrepancies with some residents recorded weights, and that staff had not taken and recorded resident #005's weight consistently every month. The RD confirmed that Goldcare would send automated referrals with any significant weight change, and that they had not received an automated Goldcare referral in March 2018.

During an interview with the ADOC, they reported to Inspector #577 that Goldcare auto-generated a "Vital Signs" electronic mail notification to the RD only for the following parameters; a 5.0 per cent weight change in 30 days, a 7.5 per cent weight change in 90 days; and a 10 per cent weight change in 180 days. [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 any other weight change that compromises their health status, is assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(d) includes alternative beverage choices at meals and snacks; O. Reg. 79/10, s. 71 (1).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle included alternate beverage choices at meals and snacks.

During observation of a particular meal service on a specific resident home area, on a day in May 2018, Inspector #621 reviewed the home's menu cycle. The menu cycle provided information regarding alternate beverage choices for meals; however, the menu provided no information with regards to between meal nourishment, including what alternate beverage choices were to be offered.

During an interview with Dietary Aide #107, they reported to the Inspector that there was no snack menu cycle available on the specific home area for review.

During an interview with the Food Services Supervisor (FSS), they identified to Inspector #621 that the home's snack menu cycle was separate from the main menu, and was not posted on the units.

On review of the home's snack menu, the Inspector found no information identifying what alternate beverage choices were offered with between meal snacks.

During a review of the home's main menu and separate snack menu cycles, the FSS confirmed with Inspector #621 that the home had not ensured that the home's complete menu cycle included alternate beverage choices at snacks. [s. 71. (1) (d)]

2. The licensee has failed to ensure that planned menu items were offered and available at each meal and snack.

During observation of a particular meal service on a specific home area, on a day in May 2018, Inspector #621 reviewed the home's posted four week menu cycle.

Inspector #621 observed during the meal service, resident's #032, #033 and #034 being offered a texture modified meal option, which was visibly different to the main and alternate entree options specified on the planned menu.

The Inspector reviewed the resident diet census for a specific resident home area, last revised in May 2018, which identified resident #032, #033 and #034 were on a specific modified diet texture.

During an interview with Dietary Aide #107, they reported to Inspector #621 that the residents who were the modified diet texture received menu items different from what was identified on the planned menu. When the Inspector inquired as to what was being provided instead for those residents on the specific modified diet texture, Dietary Aide #107 indicated that residents would receive either a texture modified meal that was prepared in house, or a commercial texture modified product that had been outsourced. Dietary Aide #107 confirmed to the Inspector that the options available for residents on the specific texture modified diet were not the same as what was available for other residents from the planned menu.

During an interview with PSW #103, they reported to Inspector #621 that for that unit, there was only one specific texture modified menu item made available to residents on a certain texture modified diet, and the menu item was not comparable to the main or alternate entree served from the main menu to the rest of the residents.

Further, PSW #103 identified that there were only two other residents in the home who

received a choice between two texture modified menu options at meals, and that was because those residents could make their own decisions, and wanted a second option available to them. When the Inspector inquired which residents on the specific unit required a a specific modified diet texture, PSW #103 indicated that resident's #032, #033 and #034 required the stated diet texture.

During an interview with the Food Services Supervisor (FSS), they identified to Inspector #621 that the planned menu posted in each unit dining area of the home was for all diet types. The FSS reported that they expected that the food service cooks processed the planned menu items to a certain texture, or utilize a commercial protein and vegetable product of the same required consistency that was purchased for this purpose, and comparable to the main menu item they were to replace.

On a day in May 2018, Inspector #621 and the FSS met with Cook #137. Cook #137 reported to the Inspector that they were preparing two specific menu options, consistent with the planned menu. Additionally, Cook #137 indicated that they were making different items for the specified texture modified diets, and proceeded to identify each item. The FSS confirmed to the Inspector that the planned menu items on the home's menu cycle were not offered and available to residents on the specific texture modified diet. [s. 71. (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 the home's menu cycle includes alternate beverage choices at meals and snacks; and to ensure that planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the food production system, at a minimum, provided for communication to residents and staff of any menu substitutions.

During a specific meal service on a particular resident home area, on a day in May 2018, Inspector #621 observed the provision of one texture modified meal option to residents #031, #033, #034 and #037, with no communication of what the menu option was by Dietary Aide #107 to PSWs #103 and #130, or by PSWs #103 and #130 to the residents. The Inspector also observed that the meal that was offered was visibly different to either the main and alternate menu options identified on the planned menu.

During an interview with Dietary Aide #107, they reported to Inspector #621 that the residents who were on the specific modified diet texture would receive menu items different than what was identified on the planned menu. When the Inspector inquired how menu substitutions were communicated to residents and staff, Dietary Aide #107 reported that they would inform the staff, who would then tell the resident what the options were.

During an interview with PSW #103, they reported to Inspector #621 that Dietary staff never kept unit staff informed as to what was being served for the residents who were on a certain diet texture, unless unit staff specifically asked. PSW #103 indicated that there was no other method that the home used to communicate what was being served for the specified texture modified diet, and that the menu items were often different than what was posted on the menu and served to other residents.

During an interview with the Food Services Supervisor (FSS), they identified to Inspector #621 that when the home's cooking staff made menu substitutions, they were expected to inform the dietary aides, who would then communicate the substitutions to the PSW staff on the units. Further, it was expected that PSW staff would then inform the residents and/or their families of the changes. The FSS confirmed that if there was breakdown in communication between staff regarding any menu substitutions, that the home did not utilize an alternate method of communicating menu substitutions to residents and unit staff. [s. 72. (2) (f)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the food production system, at a minimum, provides for communication to residents and staff of any menu substitutions, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide assistance required by the resident.

On a day in May 2018, during a particular meal service on a specific home area, Inspector #621 observed resident #009 offered soup, which remained untouched starting from a specific time. A specific time later, PSW #130 was observed offering resident #009 a main entrée, while the soup remained in front of the resident untouched.

During an interview with PSW #130, they reported to Inspector #621 that resident #009 required assistance from staff to eat and drink, as they could not complete the task on their own. When the Inspector inquired if a meal was to be served to the resident prior to staff being able to assist them, PSW #130 reported "no, that's my bad", and then continued to serve other residents for a further specified time period, before sitting down with resident #009 to assist them with their meal.

During an interview with the DOC, they confirmed with Inspector #621 that no resident who required assistance with eating a meal was to have a meal served to them until a PSW or registered staff member was available to provide assistance. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide assistance required by the resident, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances in the home were labelled properly and kept inaccessible to residents at all times.

During a tour of the home, Inspector #577 observed that the door to a housekeeping closet on a specific resident home area was unlocked, which allowed the door to be opened. Inspector #577 opened the door to the housekeeping closet and observed one bottle of industrial cleaner which had a Workplace Hazardous Materials Information System (WHMIS) symbol label that identified it to be "toxic and corrosive" and two bottles of disinfectant solution with labels that identified them to be "very toxic, highly irritating and corrosive".

Inspector #577 spoke with Housekeeping Aide #142, who confirmed that the door to the housekeeping closet, was unlocked, and indicated that the door was to be kept locked.

In an interview with the Environmental Service Manager (ESM), they indicated to Inspector #577 that all doors to the housekeeping closets were to be locked, and together with the Inspector, observed the housekeeping closet on the specific resident home area. The ESM removed the bottle of industrial cleaner and two bottles of disinfectant solution from the closet, as they reported that the home had discontinued the use of these products one year prior, and that they could no longer be found in the home's WHMIS manual.
[s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances in the home are labelled properly and kept inaccessible to residents at all times, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber.

A Critical Incident System (CIS) report was submitted to the Director for an incident relating to alleged abuse/neglect of resident #012. The CIS report identified that a medication error had occurred in which a medication was ordered by a prescriber for resident #012, but was not given until four weeks later.

Inspector #693 reviewed the prescriber's orders for a date in June 2017, for resident #012, which included a signed and dated order for a certain medication to be administered at specific intervals of time to the resident. The physician's order sheet was signed by a registrant to indicate that the order had been faxed to the pharmacy and then signed off by another registrant to indicate that the order had been transcribed to the electronic Medication Administration Record (e-MAR).

Inspector #693 reviewed resident #012's e-MAR over a specific time period between June and August 2017, and identified that the medication order made on a specific date in June 2017, was not recorded on the e-MAR for that time period.

Inspector #693 reviewed the progress notes for resident #012 from a date in August 2017, which indicated that the pharmacy had contacted the nurse of duty to inform them that the order for the medication had not been received and processed by the pharmacy.

In an interview with Inspector #693, RPN #100 reported that the home's process for new medication orders was as follows:
- Once the order was written, it was to be faxed to the pharmacy by the nurse on duty;
- The nurse was to then chart in the resident's electronic progress notes that there was a new order; and
- The nurse on duty was to double check the order and make sure it had been transcribed onto the resident's e-MAR.

Inspector #693 and RPN #100 reviewed the prescriber's orders, e-MAR and progress notes for resident #012 from the period between June and August 2017. From the review, RPN #100 confirmed to the Inspector that the specified medication order made on a certain day in June 2017, was not on the e-MAR and had not been administered to the resident from a specific date in June 2017 until another specific date in August 2017. RPN #100 also confirmed that the nurse on duty had signed off that the order had been sent to the pharmacy, and that a second nurse had signed off on the order record to show that it had been transcribed to the e-MAR, when it had not.

A review of the home's policy entitled "Policy 090: Medication and Treatment Orders", last revised July 2017, identified that the registrant must transcribe and process all prescriber clinical orders with care and accuracy to ensure safe delivery and accurate recording of the resident's treatment and medication program, and that it was the responsibility of the night registrant on each unit to double check all resident charts for new orders, and validate that all medications had been processed accurately on the correct medication administration record.

In an interview with Inspector #693, the ADOC reviewed the prescriber's orders, progress notes and e-MAR for resident #012 for the specified time period. The ADOC confirmed to the Inspector that a nurse had signed the prescriber's order, indicating that the order had been sent to the pharmacy, and that another nurse had signed to indicate that it had been transcribed to the e-MAR, but that the order had not been transcribed. The ADOC also confirmed that the specific medication order was not indicated on the e-MAR between the specific time period between June and August 2017, and that the medication had not been administered to resident #012 during that time period. [s. 131. (2)]

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

During the inspection, resident #004 was identified by Inspector #577 to have had a weight change.

During review of resident #004's weight record, the Inspector identified a specific documented weight change between January and March 2018.

Inspector #577 reviewed resident #004's health care record, which identified an order

written by the Registered Dietitian (RD) on a day in May 2018, instructing staff to provide resident #004 with a specified amount of a particular type of nutrition supplement over a certain time interval.

During a review of resident #004's electronic Medication Administration Record (e-MAR), Inspector #577 identified that nutrition supplement order made by the RD on a particular day in May 2018, was not administered to the resident until seven days later.

Inspector #577 interviewed the RD, who reported that resident #004 was at high nutrition risk.

During an interview with RPN #112, they confirmed with Inspector #577 that the nutrition supplement ordered on a specific date in May 2018, by the RD for resident #004 had been faxed to the pharmacy and added to the e-MAR, but that RPN staff had not administered the nutrition supplement to the resident until seven days later. [s. 131. (2)]

Additional Required Actions:

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

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that, there was, at least quarterly, a documented reassessment of each resident's drug regime.

During a review of resident #009's restraint documentation, Inspector #617 identified that a physician's order for the use of the resident's restraint device was located on a medication review with a quarterly reassessment and review period between February and May 2018. The Inspector noted that this medication review and physician order for the use of resident #009's restraint device had been expired for a period of five weeks.

Together with Inspector #617, RPN #112 reviewed resident #009's medication review and confirmed that the review dated between February and May 2018, was outdated and the physician orders in the review were not valid. Additionally, RPN #112 identified to the Inspector, that at the time of inspection, a more current medication review was not available for this resident.

A review of the home's policy titled, "Residents' Quarterly Medication Reviews/Physician Reviews - #180", with no revision date, identified that physician's orders expired every three months and the pharmacy was to compile and provide the home with the residents' medication reviews quarterly, on a rotating schedule. Additionally, the policy identified that reviews were to be provided to the home one month prior to the start of the date

range on the Physician's Medication Review document, and left in the physician's binder to be completed on the physician's next visit. Furthermore, once the quarterly reviews were obtained from the pharmacy, it was the responsibility of the RN on duty to ensure that the reviews were accurate and reflected current orders. Finally, the policy also indicated that the resident's physician was responsible to check the quarterly review and either continue or discontinue each ordered medication, as well as sign and date the orders, so that a current medication and treatment profile for the resident was available.

In an interview with RN #119, they reported to Inspector #617 that several of the residents' medication reviews in the home that were not current. RN #119 further explained that the RN on duty was required to review and compare the quarterly medication reviews to the physician's orders on the resident's chart, update the review if required, and get the physician to sign the review once completed. In an interview with RPN #100, they reported to the Inspector that medication reviews for several residents on Units One and Two was not current, with updated reviews not yet processed and signed off by the physician.

On a specific day in June 2018, Inspector #627 found a total of 75 resident medication reviews in a folder labelled, "Medication Reviews for RN to check and prepare for physician" on each of the home's nursing units, which had not been reviewed or signed off by the physician. For the review period between specific dates in May and August 2018, the Inspector identified medication reviews for the following 41 residents incomplete:
Resident's #006, #008, #009, #015, #017, #018, #023, #026, #032, #035, #036, #039 - #047, #049 - #060, #062, #064 - #069, and #072. Additionally, for the review period between specific dates in June and September 2018, the Inspector identified medication reviews for the following 34 residents incomplete: resident's #013, #019, #031, and #073 - #103. Consequently, 75 out of 116 residents, (or 65 percent), had incomplete quarterly medication reassessments.

Inspector #617 interviewed RN's #118 and #138, who both reported that on a specific date in June 2018, the pharmacist from the home's Pharmacy Service Provider dropped off the quarterly medication reviews which were dated between specific dates in May and August 2018, as well as June through September 2018.

RN #138 confirmed that the home's policy indicated that the pharmacy was to provide the residents' medication reviews one month prior to the start of the date range; and consequently, the medication reviews should have been provided to the home by a

specified date in April 2018, for the May through August 2018, date range, and by a specified date in May 2018, for the June through September 2018, date range. RN #138 identified to the Inspector that medication administration using expired orders was not a safe practice, nor was it consistent with the home's policy or College of Nurses in Ontario (CNO) standard.

Inspector #617 interviewed Pharmacist #139, who confirmed to the Inspector that they had dropped off medication reviews for residents on a specific day in June 2018, which had been dated for the periods between May and August 2018, and June through September 2018. Pharmacist #139 confirmed that the medication reviews were provided to the home late, and as a consequence, 75 residents did not have a quarterly medication regime reassessment as required. Additionally, Pharmacist #139 confirmed that use of out dated medication reviews by home indicated that the physician's orders were expired.

In an interview with the DOC, they confirmed to Inspector #617 that there were several resident medication reviews for May and June 2018, that were not yet reviewed by the RNs and signed off by the residents' physicians, and as a consequence, residents did not have their medication regime assessed on a quarterly basis. [s. 134. (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, there is, at least quarterly, a documented reassessment of each resident's drug regime, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Inspector #577 conducted a review of the home's medication incident reports with a focus on the following three narcotic medication incidents:
- On a specific date in February 2018, a specified medication incident was documented to have occurred. The incident report indicated that the resident, the resident's substitute decision-maker (SDM), and the Medical Director were not notified of the incident;
- On a specific date in January 2018, a medication was ordered for resident #029, and

RPN #140 discontinued the medication without an order the next day. The incident report identified that the medication was reordered by the physician on a specific date in February 2018, but not restarted until nine days later. The report further indicated that the resident, the resident's SDM, the attending physician and the Medical Director were not notified of the incident; and
- On a specific date in April 2018, resident #030 was not given their scheduled medication. The incident report indicated that the resident's SDM, the pharmacy and the Medical Director were not notified of the incident.

Additionally, for all three medication incidents, Inspector #577 identified that immediate actions taken to assess and maintain the residents' health were not documented.

A review of the home's policy titled "Medication Incidents and Adverse Drug Reactions - #190", last revised in July 2017, indicated the following:
- Every medication incident involving a resident and every adverse drug reaction must be documented, together with a record of the immediate actions taken to assess and maintain the residents' health; and
- A medication incident involving a resident or adverse drug reaction must be reported to the resident, the resident's SDM, the DOC, the Medical Director, the prescriber of the drug, the resident's attending physician or RN Extended Class, and the pharmacy service provider.

During an interview with RN #138, they reported to Inspector #577 that following a medication error, staff were required to document the incident on a medication error form, and forward the form to the ADOC and/or DOC, as well as notify the physician and sometimes notify the family.

During an interview with the ADOC, they confirmed with Inspector #577 that the resident's SDM, and the Medical Director had not been notified for all three of the medication incidents; that the residents were not notified for two of the incidents; and that immediate actions taken to assess and maintain the residents' health status had not been documented for all three incidents. [s. 135. (1)]

2. The licensee has failed to ensure that a written record was kept of the quarterly review undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

Inspector #577 conducted a record review of the home’s Pharmacy and Therapeutics Committee meeting minutes dated from a specific date in March 2018, which identified “medication incidents” as an agenda item of discussion. The minutes indicated that the committee had reviewed incidents with regards to the use of communication sheets and minor changes to the electronic Medication Administration Record (e-MAR), but there was no documentation specific to a quarterly review being completed and analyzed of all medication incidents and adverse drug reactions since the previous quarter.

Inspector #577 reviewed the home's policy titled "Medication Incidents and Adverse Drug Reactions - #190", last revised July 12, 2017, which indicated the following:
- All medication incidents (whether involving a resident or not) and adverse drug reactions were to be documented, reviewed and analyzed. Corrective action was to be taken as necessary to respond to incidents, and a written record was to be kept of the review, analysis and corrective action taken; and
- The home was required to review all medication incidents and adverse drug reactions quarterly in order to reduce and prevent incidents and adverse reactions. Additionally, it was identified that any changes and improvements identified in the review were to be implemented and a written record was to be kept of the quarterly review, changes and improvements made.

During an interview with the ADOC, they reported to Inspector #577 that the Pharmacy and Therapeutics Committee discussed medication incidents but had not kept a written record of quarterly reviews undertaken. [s. 135. (3) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if can, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider; and to ensure that a written record is kept of the quarterly review undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review, in order to reduce and prevent medication incidents and adverse drug reactions; and to ensure that a written record is kept of the quarterly review undertaken of all medication incidents and adverse drug reactions that occur in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The home failed to ensure that they were equipped with a resident-staff communication and response system that was available at each bed, toilet, bath and shower location used by residents.

During observations made on a specific date in May 2018, Inspector #577 observed residents #003 in bed; their communication device affixed to an adjacent wall and not within reach. Additionally, resident #013's communication device was not within reach, with the device affixed to an adjacent wall from where they were seated.

The following day, Inspector #577 made the same observations, and measured the distance from resident #003 and #013's beds to the wall where the communication device was affixed, and found the distance to be a specific amount.

During an interview with RPN #143, they and Inspector #577 observed the communication device placement in the rooms of both resident's #003 and #013. RPN #143 confirmed to the Inspector that the communication device was not within reach of either resident when they were in their beds.

During an interview with the Environment Services Manager (ESM), they and Inspector #577 observed the placement of the communication device in resident #003 and #013's rooms. The ESM confirmed to the Inspector that the communication device was inaccessible to both residents if they were lying in their beds, and it was expected that resident the device was kept within reach. [s. 17. (1) (d)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

During three days in May 2018, Inspector #577 observed residents' personal items on a shelf, in a tub room which were unlabelled and unclean. These unlabelled items included:

- One black, one green and one yellow brush embedded with hair;
- One black comb embedded with hair; and
- One box containing 11 black combs that were soiled with hair debris.

During an interview with PSW #144, they and Inspector #577 observed the unclean and unlabelled personal items in the tub room. PSW #144 reported to the Inspector that the items should have been labelled with resident names or disposed of.

During an interview with RPN #143, they and Inspector #577 observed the unclean and unlabelled personal items in the tub room. RPN #143 reported to the Inspector that all personal items should not have been left unlabeled and in the tub room, and proceeded to discard them.

A review of the home's policy titled "Infection Prevention and Control Routine Precautions – OHS 410", last revised December 2017, indicated that personal care supplies, such as razors, hairbrushes, and antiperspirants, were to be marked with resident identification to prevent unintended use by others. Additionally, the policy identified that used and unmarked items were to be disposed of.

Inspector #577 interviewed the DOC, who reported that it was their expectation that staff labelled all hair brushes and combs with the respective residents' name, and that those personal items were kept in a personal basket in the resident's room. [s. 37. (1) (a)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the Family Council had advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), within 10 days of receiving the advice, the licensee responded to the Family Council in writing.

A review of the home's policy titled, "Family Council - #ADM 535", indicated that the Family Council was to advise the licensee of any concerns or recommendations the Council had about the operation of the home. The licensee had a duty to respond within 10 days of receiving the advice.

Inspector #617 reviewed electronic mail (e-mail) correspondence from a specific day in November 2017, between the President of Family Council (FC) and the Administrator, which identified three recommendations that resulted from round table discussions at the FC meeting. These recommendations included:
- A request to add a clock in the main entrance of the home to facilitate visitor sign in;
- A ramp be installed from Unit One to the garden, due to difficulty residents had with their wheelchairs; and
- A request for FC to be notified of new admissions for introductions.

The Administrator was identified to have responded to the three recommendations of FC in a written letter to the FC President dated on a particular day in January 2018, which was two-and-a- half months after the home was made aware of the Council's recommendations.

In an interview with FC President, they reported to the Inspector that they communicated all recommendations from the FC Meetings to the Administrator by e-mail. The FC Present confirmed to the Inspector that on a specific date in November 2017, they had e-mailed the Administrator three recommendations from the FC and did not receive a response to those recommendations until a specific date in January 2018.

In an interview with the Administrator, they confirmed to Inspector #617 that the home was aware of the three recommendations e-mailed from the FC President in November 2017, but did not respond within 10 days to the Council as required. [s. 60. (2)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response was made to the person who made the complaint, indicating: i) what the licensee did to resolve the complaint, or ii) that the licensee believed that the complaint was unfounded and the reasons for the belief.

A complaint was received by the Director alleging improper care of resident #001 by home's staff.

On review of a letter faxed on a specific date in January 2018, from the complainant's legal representative, it was alleged that there had been multiple incidents demonstrating that resident #001's care needs were not met, which included a specific allegation that the resident had a weight change as a consequence of a certain care activity not being

adequately provided. On review of the letter of response from the home's Administrator the next day, it was identified by the Inspector that the letter did not provide a response to the lack of care and weight change allegations made by the complainant.

During an interview with the Administrator, they confirmed to Inspector #621 that the letter from the complainant's legal representative on a specific date in January 2018, alleged improper or incompetent care of resident #001 resulting in a weight change, and that an investigation into the allegation along with correspondence back to the complainant regarding the outcome of the investigation did not occur.

See WN #1, finding 1, for further details. [s. 101. (1) 3.]

2. The licensee has failed to ensure that a documented record was kept in the home that included: a) the nature of each verbal and written complaint; b) the date the complaint was received; c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; d) the final resolution, if any; e) every date on which any response was provided to the complainant and a description of the response; and f) the response made in turn by the complainant.

A complaint was received by the Director alleging improper care of resident #001 by home's staff.

On review of a letter faxed on a specific date in January 2018, from the complainant's legal representative, it was alleged that there had been multiple incidents demonstrating that resident #001's care needs were not met, which included a specific allegation that the resident had a weight change as a consequence of a certain care activity not being adequately provided.

On review of the letter of response from the home's Administrator the next day, the Inspector found no response from the home to the complaint and their allegations regarding the home's lack of care and resident #001's consequent weight change.

During an interview with the Administrator, they confirmed to Inspector #621 that the letter from the complaint's legal representative on a specific day in January 2018, had alleged improper or incompetent care of resident #001 resulting in an identified weight change; that the home had not reported the allegation of potential neglect immediately to the Director; and as a consequence, compilation of the required documentation as part of

an investigation into the allegation did not occur.

See WN #1, finding 1, for further details. [s. 101. (2)]

Issued on this 31st day of July, 2018

[redacted]

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

Original report signed by the inspector.