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 28, 2017	2017_640601_0017	013368-17	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

PLEASANT MEADOW MANOR
99 Alma Street P. O. Box426 Norwood ON K0L 2V0

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

KARYN WOOD (601), LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 17, 18, 19, 20, 21 and 24, 2017.

Log #030799-16 submitted by the home regarding allegations of staff to resident abuse/neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (Admin/DOC), Clinical Care/RAI Coordinator (CCC), Life Enrichment Coordinator (LEC), Nutritional Care Manager (NCM), Physiotherapist (PT), Physiotherapy Assistant (PTA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aide, President of the Resident Council and Family Council, family members and residents.

The inspectors also toured the home, observed interactions between staff and residents, resident to resident interaction, administration of medication, infection control practice in the home and reviewed resident clinical health records, medication incidents, the licensee's applicable policies, family and resident council minutes.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

10 WN(s)
8 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 :

The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.

Related to log #030799-16:

A critical incident report (CIR) was submitted to the Director on an identified date for a suspected staff to resident neglect. The CIR indicated RPN #103 witnessed resident #021 had been neglected and received improper care. RPN #103 reported the incident to RN #104 who identified PSW #102 was the care provider for resident #021.

Interview with RPN #103 by Inspector #111 indicated that the RPN reported the witnessed neglect immediately to RN #104 and assumed the RN would have reported the incident.

Interview with the Administrator/Director of Care (Admin/DOC) by Inspector #111 indicated RN #104 did not immediately report the incident to the Director but emailed the Admin/DOC the incident indicating concern with how resident #021 was found. The Admin/DOC received the email the following day and then notified the Director two days after the incident occurred.

A compliance order was warranted due to the severity of the neglect and improper care of resident #021. Both the RPN and RN were aware of the neglect and improper care and failed to immediately notify the Director as the RN sent an email to the Admin/DOC. When the Admin/DOC became aware of the witnessed neglect and improper care the following day, also failed to immediately report the incident to the Director until the day after. The licensee has also been issued ongoing non-compliance with LTCHA, 2007, s. 24(1): during a Critical Incident Inspection (#2016_291194_0029) on October 21, 2016 as a Voluntary Plan of Correction (VPC); during a Resident Quality Inspection (RQI) (#2016_195166_0009) on April 4, 2016 as a VPC; and during a RQI (#2015_365194_0005) on February 16, 2015 as a VPC. [s. 24. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

Related to resident #020:

Inspector #111 observed resident #020 over a four day period and identified the resident had sustained a large area of tissue injury to an identified area.

Interview with RPN #106 by Inspector #111, indicated the process re: changes in skin condition, included: any tissue injury should be noted by the PSW, who would then report to the charge nurse. The nurse would assess the resident and then document in the progress note the change in skin and possible causes. RPN #106 indicated a complete head to toe assessment which would include any skin changes was completed quarterly. The RPN indicated resident #020 had fragile skin and was on medication that would make the resident more prone to tissue injury. The RPN was not aware of any current tissue injury to resident #020.

Inspector #111, interviewed PSW #107, who was the primary care provider to resident #020 indicated, the PSW had no awareness of tissue injury to resident #020's identified area.

Review of the progress notes for resident #020 had no documented evidence of when the tissue injury first occurred or possible causes. The last head to toe assessment completed for resident #020 was two months prior.

Review of the current written care plan for resident #020 related to skin indicated the resident had a potential/high risk for impaired skin integrity related to dry fragile skin due to the ageing process and impaired physical mobility. Interventions included: keep skin dry and apply lotion to dry skin when required. There was no indication the resident was at risk for tissue injury related to the use of medication and interventions to manage.

The process for identifying, reporting, identifying possible causes and documenting of the tissue injury, as indicated by RPN #106 was not clear on the resident #020's written plan of care. [s. 6. (1) (c)]

2. Related to resident #004, #013 and #015:

On July 17, 2017, resident #004 bed was observed by Inspector #601 with one quarter rail in the up position (engaged) on the right side of the bed and placed in the middle of the bed.

On July 17, 2017, resident #013 bed was observed by Inspector #111 with two quarter rails in the up position (engaged) and placed in the middle of the bed while the resident was in bed.

On July 17, 2017, resident #015 was observed by Inspector #111 in bed with the use of two quarter bed rails in the up position, placed in the middle of the bed.

Interview with PSW #117 and #118 by Inspector #111 indicated resident #004 and #013 used the half bed rails for comfort and positioning only while in bed.
PSW #117 and #118 indicated resident #015 used the half bed rails to protect the resident from injury due to an identified medical reason.

Review of the medication/ treatment administration record for July 2017 for resident #004, #013 and #015 had no documented evidence of the monitoring of the (bed rails) by

the Registered Nursing staff.

Review of the point of care (POC) for July 2017 for resident #004, #013 and #015 indicated the use of bed rails.

Review of the current written plan of care for resident #004 indicated the resident had impaired bed mobility due to an identified medical condition. The plan of care indicated the resident required two half rails up when in bed for mobility and comfort. There was no clear indication the bed rails used were quarter rails and placed in the middle of the bed.

There was also no indication (as per the Admin/DOC) that Registered Nursing staff were to monitor the bed rails in the medication/ treatment administration record and PSW's to monitor the bed rails in POC.

Review of the current written plan of care for resident #013 indicated the resident had impaired bed mobility due to an identified medical condition. The plan indicated the resident required two half rails up when in bed for mobility and comfort. There was no indication the bed rails used were quarter rails and placed in the middle of the bed. There was also no indication (as per the Admin/DOC) that Registered Nursing staff were to monitor the bed rails in medication/ treatment administration record and PSW's to monitor the bed rails in POC.

Review of the current written plan of care for resident #015 indicated the resident had impaired bed mobility due to an identified medical condition. The resident required the use of two half bed rails. There was no indication the bed rails used were quarter rails and placed in the middle of the bed. There was also no indication (as per the Admin/DOC) that Registered Nursing staff were to monitor the bed rails in the medication/ treatment administration record and PSW's to monitor the bed rails in POC.

Interview with the Admin/DOC and Clinical Care Coordinator (CCC) by Inspector #111 indicated the bed rails used in the home were half bed rails placed in the upper half of the bed and they were all considered a PASD. They both indicated they are monitored by the Registered Nursing staff on the medication/ treatment administration record and the PSW's monitor the bed rails electronically on POC. They were both unaware that the bed rails in use for resident #004, #013 and #015 were actually quarter rails that were placed in the engaged (up) position in the middle of the resident's bed.

There was no clear direction to indicate which type of bed rails were used (quarter or

half), where they were located (middle of bed), and interventions related to the use of the bed rails as per the Admin/DOC. [s. 6. (1) (c)]

3. Related to resident #007:

Inspector #601 reviewed resident #007's clinical health records and identified that resident #007 had a significant weight change over a one month period while being treated for identified medical conditions while discharged to another facility.

Inspector #601 reviewed resident #007's Reconciliation Admission Orders dated the day after the resident returned to the home and the diet was documented as a regular diet, with regular texture.

Inspector #601 reviewed the Dietitian Referrals completed by RN #116 on two specific dates and identified that resident #007 was on a regular no added salt diet with regular texture and was requesting resident #007's diet be changed to regular no added salt with minced texture. The reason given by RN #116 for the change in the diet on the two specified dates was due to the resident's declining health and having difficulties chewing.

Review of resident #007's progress notes by Inspector #601 identified the Dietitian documented two days after the resident returned to the home that staff had reported that resident #007 had a change in health and was having difficulty chewing.

Inspector #601 reviewed resident #007's Digital Prescriber's Orders and two days after the resident returned to the home, the Dietitian changed resident #007's diet to minced texture and no further changes to the resident's diet at this time.

Inspector #601 reviewed resident #007's written care plan related to the nutritional diet that was in place at the time of the inspection. It was identified that resident #007 was a high nutritional risk due to identified reasons.

The interventions in resident #007's dietary plan of care indicated resident #007 was receiving a regular diet with identified modified interventions, minced texture and identified portions.

Inspector #601's interview with RN #101 indicated that resident #007 would receive an identified portion of dessert and the same amount of protein as the other residents due to being on identified modified interventions.

Inspector #601 reviewed the Dietitian Referral completed by RN #101 nine days after the resident returned to the home indicating that resident #007 didn't want minced texture and would like to have a regular textured diet.

During an interview, the Nutritional Care Manager (NCM) indicated to Inspector #601 that according to the Meal Order Sheet, resident #007 was to receive a regular diet with minced texture and identified portions. During the same interview, the NCM indicated that located on the snack cart was a Nutritional Diet notifications to communicate the residents' diet to the staff providing the nourishment. The NCM indicated that resident #007's name was not on the Nutritional Diet notifications list upon return to the home for a specified thirteen day period.

During an interview, PSW #114 indicated to Inspector #601 that resident #007 was on a specific diet with regular texture. PSW #114 further explained to Inspector #601 that being on a specific diet meant resident #007 would receive an identified portion of dessert. PSW #114 also indicated that resident #007 was not having any difficulty chewing and told Inspector #601 that resident #007 did not require to have meat cut up or food minced.

Upon return to the home, the Physician ordered for resident #007 to receive a regular diet with regular texture and two days later, the Dietitian changed the resident's diet to minced texture. Resident #007's written plan of care indicated the resident was to receive a regular diet, with identified modified interventions, minced texture and identified portions.

Resident #007's readmission diet order signed by the Physician did not include that the resident was to receive identified modified interventions or identified portions.

The Meal Order Sheet for resident #007 did not include the identified modified interventions.

The Nutritional Diet notifications to communicate the resident's diet to the staff was not updated for all staff to be aware of the changes to resident #007's diet upon return to the home and when changes were made to the resident's diet two days after returning to the home.

The change in diet texture had not been communicated to PSW #114.

Resident #007's nutritional plan of care did not set out clear directions related to the resident's diet for staff and others who provided direct care to the resident. [s. 6. (1) (c)]

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

Related to log #030799-16:

A critical incident report (CIR) was submitted to the Director on an identified date for a suspected staff to resident neglect by PSW #102 towards resident #021. Refer to WN #01 for details.

Review of the licensee's investigation by Inspector #111 indicated:
-On an identified date and time, PSW #102 had provided improper care and neglected resident #021.
-Interview with PSW #102 indicated it was a common practise in the home to provide. PSW #102 indicated the resident's bathroom was in use and therefore the PSW was unable to get the required continence equipment. PSW #102 indicated PSW #108 assisted with the mechanical lift and the transfer of resident #021. According to PSW #102, PSW #108 then left to attend to call bells.
-Interview with PSW #108 indicated no awareness of assisting PSW #102 and resident #021.

Review of the written care plan in place at time of incident for resident #021, indicated the resident required two person extensive assistance with use of mechanical lift for toileting due to cognitive impairment and impaired mobility. The interventions included: do not leave resident unattended when on the toilet or on the commode at bedside and provide privacy. The plan of care also indicated the resident was a high risk for falls and staff to ensure the safety device was in place.

The plan of care for resident #021 was not provided to the resident as indicated in the plan related to toileting. [s. 6. (7)]

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 the plan of care sets out clear directions to staff and others who provide direct care to resident #020 related to skin, resident #004, #013, #015 related to side rails and resident #007 related to diet, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are used, (a) the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practises and, if there are none, in accordance with prevailing practises, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability.

As per the August 21, 2012 Memo to Long-Term Care Home Administrators from the Acting Director: Karen Slater regarding Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, "I would like to remind all LTC Homes about the important Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". This document can be found at http://www.hc-sc.gc.ca/dhp-mps/md-im/applic-demande/guide-ld/md_gd_beds_im_ld_lits-eng.php, previously posted on the www.ltchomes.net site on January 28, 2010. The Ministry expects homes to use this as a best practise document in their home. In addition to the Health Canada notice, I would also like to direct your attention to the regulatory requirements related to bed rails found in section 15 of the Ontario Regulation 79/10 of the Long-Term Care Homes Act, 2007, proclaimed into force on July 1, 2010".

Interview with the Admin/DOC and CCC indicated the only bed rails used in the home were half bed rails. They both indicated the home initiated 'bed rail use assessment forms' but have not completed them for all residents (only completed for 4/60 residents). They both confirmed the bed rail assessment forms were not completed for resident #004, #013 and #015. They were both unaware that the bed rails in use in the home were actually quarter rails and not half rails and were placed in the middle of the beds for twenty of the residents observed during stage one of the RQI (including resident #004, #013 and #015). The Admin/DOC indicated the home had completed the "Bed Entrapment-Reducing Risk Intervention Tool" for all the residents in the home in 2017. They were both unaware that these Entrapment Tools were all incomplete and indicated all the bed rails engaged at the top of the bed (and not in the middle of the bed) and they indicated no concerns of entrapment. [s. 15. (1) (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 where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practises and, if there are none, in accordance with prevailing practises, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

Related to log #030799-16:

A critical incident report (CIR) was submitted to the Director on an identified date for a suspected staff to resident neglect. Refer WN #01 for details.

Review of the licensee's policy "Critical Incident Reporting": (M-6.6, revised September 2013), indicated:
1. In the event a critical incident occurs after hours or on the weekend, the on-call manager shall be notified by telephone of the incident.
2. All critical incidents shall be reported to the Director of Operations at the time they

occur.

Review of the licensee's policy "Zero Tolerance of Abuse and Neglect of Residents" (AM-6.0, revised June 2016) indicated under procedure:
1. Any person who has reasonable grounds to suspect that a resident has been neglected or abused is obligated by law to immediately report the suspicion and the information upon which the suspicion is based to the Director, Home's Administrator or manager on call.
3. In the event of an allegation or complaint of abuse or neglect of a resident, the charge nurse in consultation with the manager on call shall assess the risk and severity of the incident and determine the need to relieve the accused person of their duties pending investigation.
5. In cases where a staff member witnesses/suspects/hears about an act of abuse or neglect, the first course of action shall be to ensure that the resident is taken to a safe and secure environment.
Once the resident is physically safe, the following steps shall be taken:
-Report incident to direct manager, Director of Care or Administrator
-Provide the resident with one on one supportive measures
-Assess needs for advanced medical assessment and treatment including psychosocial or physical intervention.

Review of the licensee investigation and interview of staff indicated the licensee failed to ensure the Zero Tolerance of Abuse and Critical Incident reporting policy requirements were complied with as:
- both RPN #103 and RN #104 had reasonable grounds to suspect staff to resident neglect and improper care by PSW #102 towards resident #021 on the identified date and time.
-RN #104 did not immediately contact the on call manager or the Director of Operations, the RN did not immediately relieve PSW #102 of duties and the PSW continued to provide care to residents on the identified date.
-There was no documented evidence of the incident on the resident’s health record or to indicate the RN provided one to one support or that resident #021 was assessed for physical or emotional harm. [s. 20. (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 the written policy that promotes zero tolerance of abuse and neglect of all residents is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:
(ii) Neglect of a resident by the licensee or staff.

Related to log #030799-16:

A Critical Incident Report (CIR) was submitted to the Director on an identified date for a suspected staff to resident neglect. Refer to WN #01.

Interview with the Admin/DOC by Inspector #111 indicated the investigation was started two days after the incident occurred. The Admin/DOC indicated she became aware of suspected staff to resident neglect on the day after the incident via an email, received from RN #014 regarding the incident. The Admin/DOC indicated she did not start the investigation until the following day after becoming aware because that was when PSW #102 returned to work. The Admin/DOC indicated RN #104 should have immediately started the investigation. [s. 23. (1) (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 every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: (ii) Neglect of a resident by the licensee or staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Related to log # 030799-16:

A critical incident report (CIR) was submitted to the Director on an identified date for a suspected staff to resident neglect towards resident #021. Refer to WN #01. The CIR indicated the Substitute Decision Maker (SDM) was notified of the incident.

Review of the progress notes for resident #021 had no documented evidence of the incident.

Interview with the Admin/DOC by Inspector #111 confirmed the staff to resident improper care and/or neglect towards resident #021 was not reported to the SDM until two days following the incident. [s. 97. (1) (b)]

2. The licensee has failed to ensure the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Related to log #030799-16:

A Critical Incident Report (CIR) was submitted to the Director on an identified date for a suspected staff to resident neglect towards resident #021. Refer to WN #01. The CIR indicated the SDM was notified of the outcome of the licensee's investigation on an identified date.

Review of the licensee's investigation indicated the investigation was completed six days following the incident and the outcome was founded.

Interview with the Admin/DOC by Inspector #111 indicated the SDM was notified of the outcome of the investigation eighteen days after the investigation was concluded. [s. 97. (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 the resident's SDM and any other person specified by the resident are notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of a resident; to ensure the resident and resident's SDM are notified of the results of the alleged abuse or neglect investigation immediately upon the completion, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Related to log #030799-16:

A critical incident report (CIR) was submitted to the Director on an identified date for a suspected staff to resident neglect. Refer to WN #01. The CIR indicated the police came to the home two days following the incident.

Interview with the Admin/DOC indicated the police were notified two days after the incident when the Director was notified. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed (b) corrective action is taken as necessary, and (c) a written record is kept of everything required under clauses (a) and (b).

Review of the licensee's medication incidents for the last quarter indicated there were eight medication incidents that occurred during that time period. Six of the medication incidents were related to medications not being administered as prescribed (two residents receiving the wrong medication). The remainder two were transcription errors that did not involve the resident.

Interview with the Admin/DOC by Inspector #111 indicated she did not review or analyze the medication incidents or take corrective actions as necessary to prevent/reduce medication incidents. [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 residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 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. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

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 (SDM), 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.

Review of the licensee's medication incidents for the last quarter indicated there were four medication incidents that involved the residents:

1) On an identified date and time, the pharmacy consultant was completing the drug destruction and noted resident #014 had not received an identified medication as ordered. The pharmacy completed the medication incident report and submitted the medication incident to the Admin/DOC. There was no indication the SDM and physician/Medical Director were notified. Interview with the Admin/DOC confirmed she did not contact the SDM, physician or Medical Director regarding the medication incident when she became aware of the medication incident. Review of the Controlled Substance Monitoring Record indicated RPN #115 was involved in the medication incident, noted the drug was not given. There was no documented evidence that RPN #115 assessed the resident or completed a medication incident report until over a month later when the error was discovered by pharmacy.

2) On an identified date and time, RPN #103 discovered that she/he administered three of resident #026's identified medications to resident #025 in error. Interview with RPN #103 confirmed the Pharmacy was not notified.

3) On an identified date and time, RPN #103 administered a PRN narcotic to resident #019 four hours before it was scheduled to be given. The physician order indicated the resident was to receive the identified medication every 8 hours for severe discomfort, as needed. The eMAR indicated the resident received the medication on the identified date at a specified time, and again four hours later (by RPN #103), and again five hours later (by RPN #116).

4) On an identified date and time, RPN #109 administered a high risk medication to the wrong resident (resident #028) that was supposed to be given to resident #027. Interview with RPN #109 indicated she/he left a note in the physician binder regarding the medication incident. The RPN did not contact the Medical Director or the pharmacy regarding the medication incident. [s. 135. (1)]

2. The licensee has failed to ensure that
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed

(b) corrective action is taken as necessary, and
(c) a written record is kept of everything required under clauses (a) and (b).

Review of the licensee's medication incidents for the last quarter indicated there were eight medication incidents that occurred. Four of the incidents related to medications not being administered as prescribed, two residents receiving the wrong medication, one incident written in error, and the last incident a medication not submitted by pharmacy but did not involve the resident.

Review of the Medication Review indicated it was completed by the pharmacy quarterly and identified the medication incidents, which resident was involved and any negative effects on the resident. There was no indication of corrective action or analyzed for trends. Review of those medication incidents indicated the majority of the incidents involved residents not receiving medications as ordered.

Interview with the Admin/DOC by Inspector #111 indicated she did not review or analyze medication incidents for trends or provide corrective actions as necessary to prevent/reduce medication incidents. The Admin/DOC indicated only pharmacy provided a quarterly report on medication incidents. [s. 135. (2)]

3. The licensee failed to 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; (b) any changes and improvements identified in the review are implemented; and (c) a written record is kept of everything provided for in clauses (a) and (b).

Interview with the Admin/DOC by Inspector #111 indicated the only quarterly review completed of all medication incidents was completed by the pharmacy for the previous quarter but there are no changes or improvements identified in the review to reduce and prevent medication incidents. The Admin/DOC indicated they do have Professional Advisory Meetings (PAC) meetings but was unable to provide copies of these meeting minutes.

Review of the quarterly Medication Review (from January to March 2017) completed by the Pharmacy only identified the resident's names, the medication incidents, and any negative effects on the resident. There was no indication of any changes and improvements. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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 SDM, 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; to ensure that (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed (b) corrective action is taken as necessary, and (c) a written record is kept of everything required under clauses (a) and (b); to 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, (b) any changes and improvements identified in the review are implemented, and (c) a written record is kept of everything provided for in clause (a) and (b), to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed ensure that the Family Council advice was attained in developing and carrying out the satisfaction survey.

During an interview, the Family Council President indicated to Inspector #601 not being aware of a yearly Resident/Family satisfaction survey and the licensee had not involved the Family Council in the development or carry out of the survey.

During an interview, the Life Enrichment Coordinator indicated to Inspector #601 that the Family Council was not involved in the development and carrying out of the 2017 Resident/Family satisfaction survey and the results were scheduled to be reviewed at the next Family Council Meeting. [s. 85. (3)]

Issued on this 9th day of August, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KARYN WOOD (601), LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2017_640601_0017
Log No. / No de registre :	013368-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 28, 2017
Licensee / Titulaire de permis :	Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	PLEASANT MEADOW MANOR 99 Alma Street, P. O. Box426, Norwood, ON, K0L-2V0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sandra Tucker

To Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # /
Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.

Related to log #030799-16:

A critical incident report (CIR) was submitted to the Director on an identified date for a suspected staff to resident neglect. The CIR indicated RPN #103 witnessed resident #021 had been neglected and received improper care. RPN #103 reported the incident to RN #104 who identified PSW #102 was the care provider for resident #021.

Interview with RPN #103 by Inspector #111 indicated that the RPN reported the witnessed neglect immediately to RN #104 and assumed the RN would have reported the incident.

Interview with the Administrator/Director of Care (Admin/DOC) by Inspector #111 indicated RN #104 did not immediately report the incident to the Director but emailed the Admin/DOC the incident indicating concern with how resident #021 was found. The Admin/DOC received the email the following day and then notified the Director two days after the incident occurred.

A compliance order was warranted due to the severity of the neglect and improper care of resident #021. Both the RPN and RN were aware of the neglect and improper care and failed to immediately notify the Director as the RN sent an email to the Admin/DOC. When the Admin/DOC became aware of the witnessed neglect and improper care the following day, also failed to immediately report the incident to the Director until the day after. The licensee has also been issued ongoing non-compliance with LTCHA, 2007, s. 24(1): during a Critical Incident Inspection (#2016_291194_0029) on October 21, 2016 as a Voluntary Plan of Correction (VPC); during a Resident Quality Inspection (RQI) (#2016_195166_0009) on April 4, 2016 as a VPC; and during a RQI (#2015_365194_0005) on February 16, 2015 as a VPC. [s. 24. (1)] (111)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 28th day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Karyn Wood

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