Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 25, 2020	2019_558123_0015	017416-19, 022278-19	Complaint

Licensee/Titulaire de permis

Shalom Village Nursing Home
60 Macklin Street North HAMILTON ON L8S 3S1

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

Shalom Village Nursing Home
70 Macklin Street North HAMILTON ON L8S 3S1

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

MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 15, 18, 19, 20 & 27, 2019; December 17, 18, 19 & 20, 2019 and January 3, 6, 7, 16, 21, 22, 28, 29 & 30, 2020.

Off-site inspection was conducted on the following dates: January 3, 6, 7, 16, 21, 22, 28, 29 & 30, 2020.

The following intakes were included in this inspection:
Complaint #022278-19 related to personal care and reporting and complaints and complaint #017416-19 related to reporting and complaints and responsive behaviours.
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During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSWs), registered staff, the Assistant Director of Care (ADOC), the Director of Care (DOC), the Social Service Coordinator; the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) coordinator and the Administrator.

During the course of this inspection the inspector observed residents; observed resident interactions, observed resident staff interactions; reviewed residents' health records and reviewed the home's records including policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Medication
Personal Support Services
Reporting and Complaints
Responsive Behaviours

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

- **12 WN(s)**
- **9 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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out, clear directions to staff and others who provided direct care to the resident.

The family member of resident #010 complained to the MLTC in November 2019, that the resident was not being provided aspects of personal care, at times.

The health record of resident #010 was reviewed. Identified documentation, dated August 2017, indicated the resident's substitute decision-maker (SDM) did not refuse the home's identified care program. The email communication, between the home and resident #010's family member, dated October 2019, noted the resident's family member questioned whether the provision of an identified aspect of care was part of the resident's care as they noticed the resident's had not been provided that care. They reported they provided the identified care to the resident a few times. The documentation as of December 2019, included: the resident's family member would perform the identified care as needed. The care plan, bathing focus indicated the staff were to ensure an identified aspect of care on identified days.

Resident #010's written plan of care related to toenail care, did not set out clear directions to staff and others who provided direct care. [s. 6. (1) (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 a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the licensee immediately forwarded any written complaints received concerning the care of a resident or the operation of the home to the Director.

1. The family member of resident #010 provided copies of their written complaint about the care of resident #010, which they sent to the home in October 2019. The home also provided a copy of the written complaint to the Inspector. The DOC confirmed the home did not forward the written complaint received from the family member of resident #010 to the Director.

2. On an identified date in November 2019, the family member of resident #004 submitted a written letter of concern to the home regarding the impact of the identified responsive behaviours of resident #006 on resident #004 and other residents. The home did not forward the written complaint received from the family member of resident #004 to the Director as confirmed by the DOC. [s. 22. (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 when the licensee receives a written complaint concerning the care of a resident or the operation of the long-term care home they immediately forward it to the Director, to be implemented voluntarily.

WN #3: 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 failed to ensure that where the Act or this Regulation required the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

1. According to the LTCHA, 2007, C. 8, s. 114 (2), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home's policy and procedure; Vaccine Refrigerator Temperature Monitoring, #003120.00, undated, was reviewed and it included: The At Home Leader will take the refrigerator temperature twice daily and record in the temperature logbook provided by the Public Health Department.

The home's pharmacy service provider's Medication Systems Audits, dated, January, February, April, May and September 2019, were reviewed.

i. The January 2019, first floor Medication Systems Audit, indicated the refrigerator temperatures were not consistently recorded, no dates were documented.

ii. The February 2019, second floor Medication Systems Audit, noted that there were several missing logbook entries of the refrigerator temperatures including seven identified occasions.

iii. The April 2019, first floor Medication System Audit, indicated that there were missing documentation of the refrigerator temperatures twice.

iv. The September 2019, second floor Medication System Audit, indicated there were missing logbook documentation on two identified dates.

The DOC confirmed the staff did not follow the Vaccine Refrigerator Temperature Monitoring policy and procedure.

2. The home's pharmacy service provider's policy and procedure, Drug Destruction: Non-Controlled Substances, #9.1, dated December 2018, was reviewed and it included: The Medication Destruction Form should be signed and dated by both staff members who participated in the medication destruction.

The home's pharmacy service provider's Medication Systems Audits, dated, January, February, April, May and September 2019, were reviewed.

i. The January 2019, first floor Medication Systems Audit, indicated the documentation of the destruction of non-controlled medications was not available. It was noted that the auditor could not confirm documentation of non-controlled substance destruction with the DOC as they were not available.

ii. The February 2019, second floor Medication Systems Audit, indicated the destruction of non-controlled drugs was not documented.

iii. The September 2019, first floor Medication System Audit, indicated the destruction of

non-controlled substances was not being documented. It was noted that the home should ensure that records for non-controlled substance destruction were signed and kept in the home for two years.

The DOC confirmed the staff did not follow the home's policy and procedure related to documentation of the destruction of non-controlled substance as noted above.

3. The home's policy and procedure, Residents Self Administration of Medications and Medication Administration, #011015.00, undated, was reviewed and it included: If a resident wishes to self-administer their medications, the following criteria must be met: The resident's physician approved the self-administration in consultation with the resident and health care team. The resident must be assessed as capable of self-administering medications using the Self Administration Assessment tool. The resident's ability to self-administer medications must be evaluated annually and with a change in their condition. It also indicated that nursing department staff were to administer medications as per the College of Nurses of Ontario, Standards of Practice.

i. The health record of resident #001 was reviewed and progress note documentation of an identified date in March 2019, indicated that the resident asked the registered staff to throw medications that the resident did not take into the garbage. The resident then gave the staff a quantity of an identified medication. It was also noted that the resident usually asked for their medications and took them by themselves. The staff would ask the resident if they took the medications.

ii. Progress note documentation of an identified date in November 2019, indicated that they would take the medications. The staff noted that they left the three identified medications in the resident's room as the resident requested.

The health record of resident #001 was reviewed and no documentation was found related to the resident being assessed in relation to their self-administering medications.

The DOC reported the physician had not approved resident #001's self-administration of their medications. An assessment of the resident's ability to self-administer their medications was not completed and the registered staff were required to ensure the resident took their medications or if the resident refused the medications it was to have been documented accordingly. They confirmed the staff did not follow the home's medication policy and procedure. [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 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, is complied with, to be implemented voluntarily.

WN #4: 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:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. 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 failed to 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 was dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. 2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of the complaint including the day by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. 3. A response shall be made to the person who made the complaint, indicating, what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief.

The family member of resident #010 complained to the MLTC that they sent a letter of complaint to the home on an identified date in October 2019, and they did not receive a response from the home regarding their concerns. They reported that in the letter, they expressed concern that aspects of the resident's personal care were not being provided at times and they did not want the resident to develop an identified health condition or to be hospitalized as a result. The family member provided a copy of the written concern which they indicated they sent to the home.

The home provided a copy of the written concern they received from the resident's family member and other related documents.

On an identified date in December 2019, the At Home Leader was interviewed and they reported that they verbally informed the resident's family member, who was not the family member who wrote the complaint letter, of the actions taken by the home to resolve the concerns. They confirmed they did not provide a response, verbal or written, to the family member who wrote the letter expressing concern about the care provided to resident #010.

The home failed to ensure that the family member of resident #010 who made the written complaint to a staff member was provided: a response that complied with paragraph 3 within 10 business days of the receipt of their complaint or an acknowledgement of the complaint including, the day by which they could have reasonably expected a resolution,

and a follow-up response indicating what the home did to resolve the complaint or that the home believed the complaint was unfounded and the reasons for the belief. [s. 101. (1) 1.]

2. The licensee failed to ensure that a documented record was kept in the home that included:
(a) the nature of each verbal or 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) any response made by the complainant.

On an identified date in September 2019, the MLTC received a complaint #017416-19, indicating: the home was not managing the repeated complaints of resident #001 concerning the identified responsive behaviours of a co-resident, which was having a negative impact on their health and well-being.

Resident #001 was interviewed and they reported they had complained many times to the home's staff including the registered staff and the management, for over one year about the on-gong responsive behaviours of co-residents #002, #003 and #006, which had a negative impact on their health and well being. They indicated the home had not taken action to address their concerns and the situation had not changed.

The health records of residents #001, #002, #003 and #006 including the progress notes from August 2018, were reviewed and a documented history of resident #001 expressing concern about the identified responsive behaviours of the co-residents #002, #003 and #0006, to the staff/management was noted.

From June 2019, the documentation included eight identified occasions where the resident complained to the staff about the identified behaviours of co-residents.

The Administrator and the DOC were asked to provide the home's 2018 and 2019, documented complaint records, including the complaints of resident #001 and they were not provided. The DOC confirmed the home did not have a documented record of each verbal and written complaint made to the home in 2018 and 2019, that included all the

information required. They reported that the home initiated a documented record of each complaint received in December 2019, and the staff would be provided education.

The home failed to ensure that in 2018 and 2019, a documented record of every verbal or written complaint was kept in the home. [s. 101. (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 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: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately and to ensure that a documented record is kept in the home that includes, the nature of each verbal or written complaint; the date the complaint was received; 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; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee failed to ensure that a drug record was established, maintained and kept in the home for at least two years, in which was recorded the following information, in respect to every drug that was ordered and received in the home.
1. The date the drug was ordered.
2. The signature of the person placing the order.
3. The name, strength and the quantity of the drug.
4. The name of the place from which the drug was ordered.
5. The name of the resident for whom the drug was prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug was received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4).

The home's pharmacy service provider's Medication Systems Audits of the first and second floors dated, January, February, April, May and September 2019, were reviewed

and the following was noted:
i. The January 2019, first floor Medication Systems Audit, indicated the drug record was not maintained. Ventolin and levoflox stickers from the eBOX were in the drug record but the name of the resident to bill was not included in the record. The drug record was missing some portions both in the ordered by and received by sections.
The home's January 2019, drug record was not maintained as it did not include following: the name of the resident; the signature of the person placing the order and the signature of the person acknowledging receipt of the drug on behalf of the home in respect to every drug that was ordered and received in the home as confirmed by the record review and the DOC.

ii. The February 2019, Medication Systems Audit, indicated the drug record was not maintained. It was noted that there were several missing entries in the drug record and that the drug record and Automed contained ordering and receiving details and it should be dated and signed by both the ordering/receiving nurse.
The home's February 2019, drug record was not maintained as it did not include following: the date the drug was ordered; the signature of the person placing the order; the date the drug was received in the home and the signature of the person acknowledging receipt of the drug on behalf of the home in respect to every drug that was ordered and received in the home as confirmed by the record review and the DOC.

iii. The April 2019, first floor Medication System Audit, indicated the drug record was not maintained. It was noted that the home should ensure that medications were recorded in the drug record as per regulations and the policy.
The home's April 2019, drug record was not maintained in respect to every drug that was ordered and received in the home as confirmed by the record review and the DOC.

iv. The May 2019, second floor Medication System Audit, indicated the drug record was not maintained in respect to every drug that was ordered and received in the home and was missing some ordering and receiving information. This was confirmed by the record review and the DOC.

v. The September 2019, second floor Medication System Audit, indicated the drug record was not maintained. It was noted that all medications the home expected to receive should be recorded in the drug record by both the ordering and receiving nurse. This was confirmed by record review and the DOC.

The home's drug record was not maintained as it did not include following: the date the

drug was ordered; the signature of the person placing the order; the date the drug was received in the home and the signature of the person acknowledging receipt of the drug on behalf of the home in respect to every drug that was ordered and received in the home as confirmed by record review and the DOC. [s. 133.]

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 drug record was established, maintained and kept in the home for at least two years, in which was recorded the following information, in respect to every drug that was ordered and received in the home.
1. The date the drug was ordered.
2. The signature of the person placing the order.
3. The name, strength and the quantity of the drug.
4. The name of the place from which the drug was ordered.
5. The name of the resident for whom the drug was prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug was received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4)., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: The licensee shall keep a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date those changes were implemented.

The home was requested to provide the written record of the 2018 Pain Management program evaluation and it was not produced. The DOC confirmed the requested written

record was not available. [s. 30. (1) 4.]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A. In September 2019, the MLTC received a complaint #017416-19, which indicated that resident #001 had ongoing concerns regarding the responsive behaviours of a co-resident, which was having a negative impact on their health and well-being. Resident #001 was interviewed and they reported they had complained many times to the home's staff about the identified responsive behaviours of several co-residents including resident #006.

The health record of resident #001, including the progress notes, care plan and Point of Care (POC) documentation was reviewed. The care plan, last reviewed on an identified date in October 2019, included: a focus statement that indicated the resident had an identified condition which was likely induced by the identified responsive behaviour of an identified co-resident. Interventions included: the resident was unable to engage in an identified activity when the co-resident demonstrated an identified behaviour. The interventions included actions that the resident and the staff could take to address the issue.
The resident's progress notes and the May to August 2019, POC documentation were reviewed. The review of the POC documentation related to an identified area, which included an identified problem/issue, did not include documentation on: seven identified occasions in May 2019; eight occasions in June 2019; six occasions in July 2019 and two occasions in August 2019.

The DOC confirmed the quality of the resident's identified issue/condition was not documented as noted above.

B. On an identified date in November 2019, the MLTC received a complaint, #022278-19, from a family member of resident #010 who reported that the home was not providing the resident, who had a history of responsive behaviours and an identified health issue, the assistance they required for identified aspects of personal care. They were concerned that the resident could develop a recurrence of an identified health concern/condition.

The health record of resident #010 including the care plan and the September to December 2019, POC record was reviewed.
The POC record did not include documentation on multiple identified shifts and on multiple identified dates between September and December 2019, in relation to multiple identified aspects of personal care.
The DOC confirmed the staff did not document all the personal care provided to resident #010 as noted above.

C. The health record of resident #003, including the October to December 2019, POC documentation was reviewed. The resident was noted to have a history of responsive behaviours and they required assistance with some activities of daily living (ADLs).
The October to December 2019, POC record did not include documentation on multiple identified shifts and on multiple identified dates in relation to multiple identified aspects of personal care.
The DOC confirmed the staff did not document all personal care provided to resident #003 care as noted above. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received preventative and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

The family of resident #010 complained to the MLTC that the home was not providing basic foot care services, including the cutting of toenails to the resident.

A. The resident's health record including the progress notes, care plan, Kardex and POC documentation of October to December 2019, was reviewed. The home's identified consent, record dated August 2017, indicated the resident's substitute decision-maker (SDM) declined identified specialty services, related to nail care.
The resident's care plan included: The resident was to have been provided identified care on an identified days. The Kardex direction related to the identified aspect of care indicated the resident's family member would provide the care as needed.
The resident's October to December 2019, POC documentation were reviewed and the following was noted: The October 2019, POC documentation indicated, the identified nail care was not provided on an identified date in October 2019 and on two identified dates in November 2019.

The home's records including the Foot Care Protocols, #006030.00, Hygiene, Personal Care and Grooming #005230.00 and the home's leadership meeting minutes dated November and December 2019, were reviewed.
The home's Foot Care Protocols, policy included: At admission and during the annual resident contract review, the resident will be offered the opportunity to be seen by the Advanced Foot-care Specialist or have the home's staff manage foot-care including cutting of toenails.
The home's Hygiene, Personal Care and Grooming, policy included: Each resident's fingernails and toenails will be cleaned and trimmed according to their preference and provide foot care to all residents except those with identified health conditions and who are using identified medications. For residents with the identified conditions or who are taking the identified medications, inform the registered staff of when the bath will take place and the registered staff will complete the residents' foot care.

On an identified date in December 2019, the Inspector observed resident #010 with the assistance of PSW #110 and the resident was in need of identified personal care. PSW #110 confirmed the resident was in need of nail care.

On an identified date in December 2019, the DOC indicated that the home was reviewing and revising the system for providing foot care to the residents. The leadership team met in November and December 2019. The storage, disinfection of the care supplies, policy and procedure and the podiatry services contract were discussed. The home was in the process of purchasing the new equipment/supplies and would be following through with the related education including infection prevention and control and staff education.

Resident #010 did not receive preventative and basic foot care services, including the cutting of toenails, to ensure comfort and to prevent infection as noted above. [s. 35. (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 each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified, where possible;

strategies were developed and implemented to respond to these behaviours, where possible; and actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A. The health records of residents #004 and #006 including the progress notes and care plans were reviewed. It was noted that on an identified date in September 2019, a PSW and a registered staff observed a physical altercation between resident #004 and resident #006. The registered staff intervened and assisted resident #004 to their room. PSW #105, spoke with resident #006 and assisted them to their room.

Resident #004's care plan was reviewed and it did not include a focus statement or other information related to responsive behaviours. It was confirmed by the DOC.
The home failed to ensure that when resident #004 demonstrated responsive behaviours towards resident #006 on an identified date in September 2019, the behavioural triggers for resident #004 were identified; strategies were developed and implemented to respond to resident #004's responsive behaviour towards resident #006; that actions were taken to respond to the needs of resident #004, including assessments, reassessments and interventions and that the resident’s responses to interventions were documented.

B. The health records of residents #005 and 006 were reviewed. Progress note documentation of an identified date in June 2019, indicated resident #005 became upset because they were startled when resident #006, displayed responsive behaviours. A PSW and registered staff intervened. They also warned resident #005 that it was unsafe for them to do that as resident #006 may retaliate. Resident #005 became upset at the PSW. The registered staff provided reassurance and tried to calm resident #005 down. They did not argue with the resident as that would further upset them.

The care plan of resident #005, last reviewed on an identified date in November 2019, was reviewed and it did not include any information related to the actual or potential altercation with resident #006 or other residents. This specific focus item was noted to have been last revised on an identified date in February 2018.

The DOC confirmed resident #005's care plan did not include any information related to the potential or actual responsive behaviours, triggers were not identified and strategies were not developed.

The home failed to ensure that when resident #005 demonstrated responsive behaviours

towards resident #006 on an identified date in June 2019, the behavioural triggers for resident #005 were identified; strategies were developed and implemented to respond to resident #005's responsive behaviours towards resident #006; that actions were taken to respond to the needs of resident #005, including assessments, reassessments and interventions and that the resident's responses to interventions were documented. [s. 53. (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, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible; strategies are developed and implemented to respond to these behaviours, where possible; and actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): A missing or unaccounted for controlled substance.

i. The home's pharmacy service provider's first floor Medication System Audit, dated April 2019, was reviewed and it was noted that one ampule of hydromorphone was missing from the emergency box (eBOX) and the DOC was following up.

ii. The home's pharmacy service provider's second floor Medication System Audit, dated May 2019, was reviewed and it indicated that there was one Hydromorph missing from the eBOX and it was ordered and replaced.

The Critical Incident (CI) System was reviewed, and no reports related to the above were found.
The DOC confirmed they did not have any evidence of the home informing the Director of the missing or unaccounted for controlled substances in April or May 2019.

The home did not ensure that the Director was informed of missing or unaccounted for controlled substances as noted above. [s. 107. (3) 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 the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 3. A missing or unaccounted for controlled substance, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (5) The licensee shall ensure that a written record is kept of the results of the quarterly evaluation and of any changes that were implemented. O. Reg. 79/10, s. 115 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept of the results of the quarterly evaluation and of any changes that were implemented.

The home was requested to provide a copy of the written record of the first three 2019 quarterly evaluations of the effectiveness of the medication management system, and they were not provided.
The DOC confirmed the written records were not available.

The home did not ensure that a written record was kept of the results of the first three 2019 quarterly evaluation of the effectiveness of the medication management system. [s. 115. (5)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (4) The licensee shall ensure that the changes identified in the annual evaluation are implemented. O. Reg. 79/10, s. 116 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the changes identified in the annual evaluation were implemented.

The home's 2018, annual evaluation of the effectiveness of the medication management system was reviewed. The summary included: better documentation after the start or change in antipsychotic medication was needed and better drug record book documentation for new orders. It was recommended that education be provided to staff at nurses' meetings and through pharmacy audits. There were no dates noted for the implementation of these two recommendations.

The home was requested to provide evidence of the education provided to staff at nurses' meetings or through pharmacy audits in relation to the recommendations. The information was not provided. The DOC confirmed there was no information available related to the provision of staff education as identified in the annual evaluation. The staff education was completed in Surge and no other staff education documentation was found.

The home did not ensure that two of the three changes identified in the 2018 annual review of the effectiveness of the medication management system were implemented. [s. 116. (4)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 132. Natural health products

Findings/Faits saillants :

1. The licensee failed to ensure that where a resident wished to use a drug that was a natural health product and that had not been prescribed, there were written policies and procedures to govern the use, administration and storage of the natural health product.

The health record of resident #001 was reviewed and it was noted that on an identified date in August 2019, the resident was self administering an identified natural health product brought into the home by their family member. On an identified date in August 2019, the documentation indicated the resident believed that taking the identified natural health product helped them and they did not remember the dosage of the identified natural health product that they were taking.

The DOC confirmed the resident was taking the identified natural health product and as noted in their health record. The resident kept the natural health products in their room. The natural health product was not prescribed by the resident's physician. They were not provided by the home's pharmacy service provider and they were not included in the resident's electronic Medication Administration Record (eMAR). The DOC was requested to provide a copy of the home's natural health product policy and procedure and it was not provided.
They confirmed the home did not have a written policy and procedure to govern the use, administration and storage of the natural health products which were not prescribed. [s. 132.]

Issued on this 28th day of May, 2020

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

Original report signed by the inspector.