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
Oct 6, 2017	2017_591623_0018	013371-17	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

SPRINGDALE COUNTRY MANOR
2698 CLIFFORD LINE R. R. #5 PETERBOROUGH ON K9J 6X6

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

SARAH GILLIS (623), BAIYE OROCK (624)

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): September 5, 6, 7, 8, 11 and 12, 2017

The following log was inspected:
Log#011406-17 - related to alleged resident to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Life Enrichment Coordinator, Nutritional Care Manager (NCM), Nurse Practitioner (NP),
Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Activation Aide (AA), Dietary Aide (DA), Maintenance Manager, resident's and family members.

In addition, the inspector toured the home, observed staff to resident and resident to resident interactions, resident social programs, resident meal service, medication administration and infection control practices. The inspectors reviewed clinical health records, staff education records, medication incidents, Medication Management Meeting minutes, Resident Council meeting minutes, family communication news letters, the licensee's investigation documentation, and the homes related policies; Medication Incidents, Managing Responsive Behaviours, Infection Control, Zero Tolerance of Abuse and Neglect, Reporting Incidents of Abuse, Food and Fluid Intake.

The following Inspection Protocols were used during this inspection:
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

- **7 WN(s)**
- **7 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with 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 has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident related to eating, nutritional status and sleep preferences.

Review of the clinical records for resident #020, the current plan of care indicated the following:

Eating: Set up help only, one person physical assist, independent - No help or oversight or help or oversight provided only 1-2 times during last 7 days. Refer to nutritional roster.

Nutritional Status: loss of appetite/decreased appetite, Food preferences affecting intake
Goal: Resident will maintain ability to feed self through next review date.
Interventions: Hydration; daily fluid needs are 1750ml. The meal and snack menu offers over 2000ml daily for resident choice. Refer to Nutritional Profile for details. Risk Level : Moderate.

Sleep patterns - not identified

September 11, 2017 at 1000 hours during an interview RPN #100 indicated that resident #020 never attends breakfast, and is not a morning person. RPN indicated the written plan of care should reflect that the resident often refuses breakfast, rises late in the morning and will frequently not attend lunch. RPN #100 who is a full-time staff, indicated that he/she was not familiar with the terms Nutrition Profile or Nutrition Roster that are referenced in the care plan for eating and nutrition.

During an interview September 11, 2017 at 1030 hours, PSW #107 indicated that resident #020 is assigned to eat meals in a specified dining room. PSW #107 indicated that if a resident is known to never attend a meal such as breakfast, because they like to sleep in, the plan of care should reflect this and that resident should always receive an additional snack in the morning in place of breakfast.

During separate interviews September 12, 2017 PSW #109 and #119 indicated that they were not familiar with the term Nutrition Profile or Nutrition Roster. The PSWs both indicated that they were not aware of where they would look for a resident's diet order other than the diet list that is kept in the kitchen. Both PSW's indicated that they do not use the Kardex within the Point of Care (POC) documentation system for any resident care requirements including diet and sleep preferences. Most information is passed on from shift to shift or staff ask someone who is more familiar with the resident. PSW #119 indicated that resident #020 usually sleeps late and often skips lunch.

September 11, 2017, during an interview the Director of Care (DOC) indicated that if it is the residents preference to sleep in and not attend breakfast, the plan of care should reflect this. The DOC indicated that the Registered Dietitian (RD) is responsible for the Nutritional Status section of the care plan and this should provide clear direction for staff. The DOC was not certain where to find the Nutrition Profile or Nutrition Roster that are referenced in the plan of care by the RD.

September 12, 2017 at 1315 hours during an interview RD#118 indicated that he/she updates the Nutrition and Eating sections of the care plan in Mede-Care if there are any changes when the resident's nutritional assessment is completed quarterly or on referral. Between assessments, the RD indicated it would be expected that the nursing staff would update the care plan if there was a change. RD indicated that he/she uses the term "Refer to Nutrition Roster" meaning that staff need to look at the diet section at the top of the care plan. The statement "Refer to Nutrition Profile" refers to the same location, these terms are interchangeable. The RD indicated that these terms are OMNI "lingo" and that he/she would assume front line staff should know this. The RD indicated that he/she did not feel it was necessary to write this information out in detail on the written plan of care.

The written plan of care for resident #020 did not provide clear directions to staff and others who provided care related to eating, diet order, nutrition and sleep preferences. [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 by ensuring that the written plan of care sets out the planned care requirements for each resident and provides clear directions to staff and others who provide direct care to the residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is:
(a) in compliance with and is implemented in accordance with all applicable requirements under the Act, and
(b) complied with.

As indicated in O.Reg 79/10, s. 68.
(1) (a) the organized program of nutrition care and dietary services required under clause 11 (1) (a) of the Act; and
(b) the organized program of hydration required under clause 11 (1) (b) of the Act. O. Reg. 79/10, s. 68 (1).
(2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; O. Reg. 79/10, s. 68 (2).

OMNI Food and Fluid Intake Policy #NC-1.8 (effective June 2016) indicates the following:

Purpose
- To monitor the food, fluid and supplement intake of each resident at meal and nourishment times.
- To provide a tool for monitoring and assessment of nutritional intake.

Procedure
1. After the resident has completed his/her meal, but before dishes have been cleared, the HCA/PSW shall note the amount of food consumed by the resident on their assignment sheet. It is imperative this recording is done at this time and not from memory at a later time.
2. Food intake shall be recorded in percentages based on the residents designated portion size as follows:
- if a resident consumes all of the food they have been provided, intake is 100%
- if a resident consumes 3/4 of the food they have been provided, intake is 75%
- if a resident consumes 1/2 of the food they have been provided, intake is 50%
- if a resident consumes 1/4 of the food they have been provides, intake is 25%
- if a resident refuses the food they have been provided, mark "R"
- if a resident is sleeping at the time food is offered and is not awoken, mark "S"
- if a resident is out of the home, mark "LOA"

7. The Registered Staff on night shift shall total daily fluid intake in milliliters and record in the appropriate box on intake form.
8. The Registered Staff on the night shift shall review and initial the meal intake form each shift and report any pattern (minimum 3 days) of decreased intake to the Nutritional Care Manager.
9. The Nutritional Care Manager shall review food and fluid intake records weekly to ensure that they are being completed as required. Omissions shall be reported to the Director of Care.

Responsibility

It is the responsibility of the Nutritional Care Manager to ensure that food and fluid intake

records is available for all residents as per policy.
It is the responsibility of the Nursing and Personal Care staff to record intake as per the guidelines in this policy.
It is the responsibility of the Registered staff to monitor the intake records as required.
It is the joint responsibility of the Nutritional Care Manager and the Director of Care to monitor and intake recording and ensure it is completed as required.
It is the responsibility of the Administrator to monitor compliance.

Observations of resident #020 three specific days, resident did not attend breakfast and slept late each day. Resident #020 is assigned to eat in a specific dining room for all three meals. The morning snack cart was observed on all three days to have a snack which included a muffin and cheese, that was labelled for resident #020. On September 8, 2017, at 1000 hour a snack was left at the bedside and resident did not consume the snack. On September 11 and 12, 2017, the snack was not offered to resident #020, it remained on the snack cart undelivered. Resident #020 did not attend lunch on September 8, 2017, but did however attend lunch on September 11 and 12, 2017, with 25% of meal consumed.

During an interview with inspector #623 on a specific date and time, resident #020 indicated that he/she was tired and could not wake up. The resident indicated that they just wanted to stay in bed. When asked about the snack, resident #020 indicated that they would have it later.

Review of the clinical records for resident #020 indicated that following:

Review of the OMNI Nutrition and Hydration Assessment Form and Nutritional Risk Assessment for resident #020 were completed by the Dietitian (RD) #118 in January, April and June, 2017. The assessments indicated that resident #020 has altered nutritional status and is identified as a moderate nutritional risk.

Review of the Nutritional Intake records for August and September 2017, indicated the following:
Note: Resident #020 was away from the home for five days in August.

August 2017, intake records.
Breakfast - 1 meal 50%
- 8 meals "S" (Sleeping)
- 4 meals "L" (LOA)

- 17 meals - no documentation.

Lunch - 4 meals 25%
- 2 meals 50%
- 5 meals 75%
- 5 meals 100%
- 4 meals "L" (LOA)
- 9 meals - no documentation.

Dinner - 5 meals 25%
- 7 meals 50 %
- 4 meals 75 %
- 2 meals 100%
- 2 meals "L" (LOA)
- 11 meals - no documentation.

September 2017, intake records indicate the following:
Breakfast - 1 meal 0%
- 2 meals 75%
- 5 meals - no documentation

Lunch - 1 meal 25 %
- 2 meals 75 %
- 1 meal "R" (Refused)
- 4 meals - no documentation.

Dinner - 1 meal 0%
- 4 meals 25%
- 1 meal 50%
- 1 meal 75%
- 1 meal no documentation.

During an interview September 11, 2017, PSW #107 indicated that resident #020 eats in a specific dining room, the Activity Aid (AA) assigned to that dining room is responsible to document the meal intake for that resident. PSW #107 indicated that if resident #020 refused to attend the meal or refuses to eat, then the AA should document "R" refused. That AA is then responsible to add the resident to the tray list or the list for additional snack to be offered. PSW #107 indicated that if a resident is known to never attend a

meal such as breakfast because they like to sleep in, the documentation should be "S" for sleeping and the resident should always receive an additional snack in the morning. PSW #107 indicated that the PSW staff member who administers the snack is responsible to document the intake.

September 11, 2017, during an interview RPN #100 indicated that for residents who eat in a specified dining room, the AA is responsible for documenting meal intake in Point of Care (POC). The RPN indicated that if a resident did not attend the meal, such as resident #020 who never attends breakfast, the AA would leave the POC documentation and it would be the responsibility of the PSW to document "R" refused. The PSW would also be expected to alert the RPN so that a protein snack could be ordered for 1000 hour snack cart. RPN #100 indicated that resident #020 is not a morning person and very rarely attends breakfast.

During an interview PSW #119 indicated that resident #020 does not get up for breakfast unless there is an appointment to attend. PSW indicated that resident usually sleeps in most days. PSW indicated that resident #020 is not offered a breakfast tray because by the time the meal is finished being served, it is time for the morning snack cart to be delivered. PSW indicated that there is usually a labelled snack on the morning snack cart for resident #020, but if he/she is sleeping then staff usually do not leave it. PSW indicated that the Activity Aide serves the meal in the specified dining room, where resident #020 is supposed to eat. PSW #119 indicated that it is the Activity Aides responsibility to document in the food and fluid record if resident #020 does not attend the meal.

September 11, 2017, during an interview Activity Aid (AA) #108 indicated that he/she is responsible for overseeing the meal at breakfast in the Country Cafe. AA indicated that he/ she documents the intake for the residents who attend the meal, in POC. The AA indicated that if a resident does not attend the meal then he/she will let the RPN know so that a snack or tray can be offered. AA indicated that for resident's who do not attend the dining room for the meal, he/she does not document anything. AA indicated that it is the nursing departments responsibility to document when a resident sleeps in and misses breakfast or refuses to attend the meal.

September 11, 2017, during an interview the Director of Care indicated that it is the responsibility of the person serving the meal to document the intake in POC, which includes LOA, refusal or sleeping. The DOC indicated that in the specific dining room at breakfast, this would be the responsibility of the AA. The DOC indicated that if the

resident is served a tray, the PSW would then be responsible to document the intake from the tray. The DOC indicated that if it is the residents preference to sleep in and not attend breakfast, the plan of care should reflect this. The DOC indicated that he/she does not review the food and fluid intake records for residents, and he/she was not aware that there were gaps in the documentation for resident #020.

September 12, 2017, during an interview RD#118 indicated that resident #020 is a moderate dietary risk. The RD indicated that when completing the nutritional assessment quarterly for each resident, he/she refers to the monthly weights that are charted in the electronic documentation as well as the food and fluid intake records that are completed by the staff in POC. The RD #118 indicated being aware that there were gaps in the food and fluid intake records for resident #020, where there was no documentation at all, but he/she did not notify the Administrator, Director of Care or Nutritional Care Manager (NCM) of this. The RD indicated that he/she was not aware that resident #020 skipped breakfast most days and frequently skipped lunch. The RD indicated that he/she thought if a resident didn't attend breakfast, then they would be offered a full meal tray in their room once the dining room was done being served. RD indicated that he/she felt resident #020 was independent and able to get food and fluids if they chose to.

September 12, 2017, during an interview the Nutritional Care Manager (NCM) #114 indicated that he/she started the position at Springdale one week prior. The former NCM was not available for interview at the time of the inspection.

September 12, 2017, during an interview the Administrator indicated that he/she was not aware that resident #020 had gaps in the documentation on the food and fluid intake records for August and September 2017. The Administrator also indicated that he/she was not aware that resident #020 did not attend breakfast most days and frequently did not attend lunch. The Administrator indicated that it is the expectation that all staff follow the Food and Fluid intake policy.

The licensee failed to ensure that the Food and Fluid Intake policy is complied with related to the system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration. PSW staff failed to document food and fluid intake for resident #020, registered staff did not monitor to ensure documentation was completed, registered staff failed to notify the NCM when there was a decrease in nutritional intake for three consecutive days, the DOC and NCM failed to monitor intake records to ensure they were completed and the Administrator failed to monitor for

compliance, as per Food and Fluid Intake policy #NC-1.8. [s. 8. (1) (a),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 by ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with related to nutrition and hydration, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door?

September 11, 2017, Inspector #623 observed resident #025 at the front door of the building attempting to leave. Resident was holding the interior sliding door open indicating that he/she was leaving. Two visitors were observed trying to remove the residents hands from the door and calling out for help. The door was held for approximately 2 minutes and no alarm could be heard. RPN #100 arrived to assist the visitors to remove resident from the doorway. Once resident was removed, the door closed on its own.

Inspector #623 and #624 observed the front door of the home, upon inspection of the front door Inspector #623 was able to slide the front door open using one hand and very little effort which then left the internal door ajar. Once stepping through the internal door and into the vestibule, the outside door was able to be slid open allowing access to the outside. At the time of the test there were no staff present, to witness the door being opened. There were 13 residents seated in the lounge and dining area that is immediately inside the front door at the time of the test. No alarm sounded and the door remained open. Both the internal and external sliding door have a thumb lock to lock the door manually and prevent it from opening if it was engaged.

During an interview September 11, 2017, RPN #104 indicated that resident #025 has attempted to exit the building on numerous occasions. RPN indicated that resident #025 will pull the door off of it's tracks if he/she can get it open. RPN #104 indicated that there is no alarm for the door if it is pulled or pushed open or if it is held open for a long time. Review of the current plan of care for resident #025 identified that resident will exit seek and will follow visitors out the door. Review of the progress notes for a specified period of time, indicated that resident #025 would exit seek several times a week requiring redirection by staff, and on a specific date and time, resident #025 was found by visitors in the driveway outside of the home.

September 11, 2017, during an interview with the DOC, Inspector #623 and #624 demonstrated the ease that the front door could be opened and that there was no audible alarm activated when the door was held open. The DOC indicated that the front door does not have an alarm like the other doors to the outside. The DOC indicated that there was no lock on the front door for fire safety purposes.

September 11, 2017, during an interview with Inspector #623, Maintenance #115 indicated that he/she was not aware if the front door could be locked, other then the thumb lock that can be manually locked on both the internal and external front doors. Maintenance indicated that the only alarm on the front door was for the wander guard system.

On September 11, 2017, after further investigation by the Maintenance #115 and the DOC, it was demonstrated that the front door in fact did have the ability to lock but the key had been set to automatic for the front door, rather then in the lock position. Maintenance #115 verified that the front door setting had been turned to lock so the internal front door could no longer be slid open manually. Maintenance indicated that the door service company would be attending the facility in the morning to install an alarm on the front door and until that time there would be a staff person in place to monitor the front door for safety. Maintenance indicated that the only people with a bypass key for the front door are the Administrator, the Charge Nurse and maintenance. Maintenance indicated that education would be provided for all Registered Staff to inform them of the proper position of the front door lock.

September 12, 2017, at 1330 hours observations by Inspector #624 of the front door. The repair technician demonstrated the front door to be locked. Once the internal door was opened using the key pad, the technician demonstrated that if the door was held for 30 seconds, an alarm would sound at the front door and was also audible through the call bell system. The technician demonstrated that the only way to cancel the alarm was at the source, the front door.

The licensee failed to ensure that the home's main exit door is kept closed and locked and equipped with an audible door alarm. [s. 9. (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 by ensuring that all doors to the home leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to are kept locked, equipped with a door access control system that is kept on at all times and equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident-staff communication and response system, or is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to immediately notify the Director of an incident of physical abuse of resident #003 by resident #021.

Related to log #011406-17

Critical Incident Report (CIR) was submitted to the Director on a specified date. As identified in the submitted CIR, resident #021, who was cognitively impaired and demonstrating responsive behaviors, had approached resident #022 from behind while resident #022 was sitting in a chair. Resident #021 pulled the strings of resident #022's night gown causing red marks which disappeared shortly after the two residents were separated and assessed.

During a review of the progress notes for resident #021 for a four month period, it was documented that on a specified date, a PSW staff observed resident #021 push resident #003 causing resident #003 to fall on the floor. A post fall assessment was completed of resident #003 following the fall in which resident #003 complained of soreness and feelings of stiffness. According to the progress note, the on-call Manager who was the Administrator, was notified of the incident.

A review of critical incidents submitted to the Director indicated that the incident that was documented on the specified date, of resident to resident physical abuse was never reported to the Director.

In an interview on September 11, 2017, with the RN #106 who had written the progress note on the specified date, indicated that the licensee's expectation is that any alleged incident of resident abuse has to be reported immediately to the Director. RN #106 indicated that the Administrator was made aware of the incident after the incident occurred and was to call the Ministry of Health to report the incident.

In an interview with the Director of Care (DOC) on September 11, 2017, the DOC indicated that the licensee's expectation is any alleged, witnessed or suspected incident of resident abuse must be reported immediately to the Director. The DOC indicated in the same interview that there is no record of the incident that occurred on a specified date, being reported to the Director and the expectation is that all suspected, alleged or witnessed abuse is reported. In the same interview the DOC also indicated that registered staff are aware and have the number to call the Director directly. [s. 24. (1)]

2. The Licensee failed to immediately report two separate incidents of physical abuse of resident #025 by resident #026 and of resident #027 by resident #025.

On a specific date it was documented in the progress note of resident #025 that at a

specific time two staff members observed an initial incident involving resident #026 and resident #025 . Post incident assessment of resident #025 indicated that the resident required treatment for an injury. RN notified Environmental Manager #115 and together went through the decision tree for reporting physical abuse. Discussed that it was believed that resident #025 had not sustained a critical injury therefore reporting was not required. Environmental Manager was in contact with the Administrator and she agreed with the decision to not report. Environmental manager stated to writer that Administrator had left a message with the OMNI Director of Operations from head office to notify of the incident."

On a specific date, it was documented by RPN #116 in the progress notes, of resident #025 that staff witnessed resident #025 in the room of resident #027 at a specific time. During this observation, resident #025 was observed "grabbing forcefully onto resident #027's specified area and repeatedly hitting co-resident with a closed fist." A review of the progress notes for resident #027 on the date of the incident indicated the post incident assessment of resident #027 stated: resident #027 was visibly upset and crying and resident #027's initial injury resulted in redness to the area.

A review of the Critical Incident Reporting System indicated that none of these incidents of resident to resident physical abuse were reported to the Director.

In an interview with RPN #116 who had documented the incident on a specific date, indicated that the home's expectation is that any incident of alleged, witnessed or suspected abuse has to be reported immediately to the Director. RPN indicated that he/she believes the incident was not reported to the Director. RN #117 who was the charge nurse on shift and in the home on the specified date, when the incident occurred was not available for interview.

During an interview with the Administrator on September 12, 2017, he/she indicated that the expectation of the licensee is that any alleged, witnessed or suspected incident of resident abuse must be reported immediately to the Director. At the time of the incident that occurred on a specific date, the description provided to the Administrator by the on-call manager, did not indicate that an injury had occurred. The Administrator felt that since there was no indication the resident was injured the Administrator advised that reporting was not necessary. After reviewing both incidents with the Inspector, the Administrator now indicates that both incidents meet the definition of physical abuse and should have been reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the Director is immediately notified of any alleged, suspected, or witnessed abuse of a resident by anyone, to be implemented voluntarily.

WN #5: 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 behavioural triggers were identified for the resident #021 who was demonstrating responsive behaviours.

Related to log #011406-17.

Critical Incident Report was submitted to the Director on a specific date. As indicated in the CIR, resident #021 who was cognitively impaired and demonstrating responsive behaviors, had approached resident #022 from behind while resident #022 was sitting in a chair. Resident #021 pulled the strings of resident #022's night gown, causing red marks which disappeared shortly after the two residents were separated and assessed.

A review of the progress notes for resident #021 for a specific time period, indicated

specific behaviors were identified. The progress notes also indicated that a range of pharmacological and non-pharmacological interventions were put in place to manage those behaviors with behaviors noted to have decrease for a specific time frame, with a decline in resident's mobility status.

A review of resident #021's initial MDS assessment, and the Quarterly assessment, indicated that resident exhibits specific behaviours.

A review was completed of the initial and subsequent written plan of care for resident #021. No responsive behaviors, triggers or interventions are identified in either written plan of care for resident #021. There was also no Behavioural Assessment Tool (BATool) completed for resident #021.

On September 11, 2017, during separate interviews with Inspector #624, PSW #109, PSW #110, and RN #106, PSW #109 indicated that care being provided and resident not understanding what was going on as triggers; PSW #110 indicated that he/she was not aware of resident #021's behavioural triggers. RN #106 indicated resident #021's triggers were care being provided and other residents getting in the way.

During an interview the DOC indicated the licensee's expectation is that for residents with responsive behaviors, those behaviors, triggers – if known, and interventions to manage those behaviors should be identified, in the resident's plan of care.

The licensee failed to ensure that the known responsive behaviours, triggers and interventions for resident #021 were identified when the resident was exhibiting identified responsive behaviors. [s. 53. (4) (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 by ensuring that for each resident demonstrating responsive behaviours, that behavioural triggers are identified where possible, strategies developed and implemented to respond to the behaviours, where possible, and actions are taken to respond to the needs of the resident, including assessment, reassessments and interventions and the resident's response to the interventions are documented, to be implemented voluntarily.

WN #6: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Review of the progress notes for resident #023 indicated that on a specific date and time, a medication incident occurred. The progress note indicated the following;
RN #102 at a specific time resident #023 was given co-resident #024's medications. When RN tried to give resident #023 the scheduled medication the resident refused. A Medication Incident Report was filled out. Resident #023 was monitored and no adverse effects noted.

During an interview September 7, 2017, RN #102 indicated that on a specific date, he/she administered resident #024's medications to resident #023. RN #102 indicated that he/she signed the eMAR as given and then realized that he/she had administered the wrong medications to resident #023. RN indicated that he/she attempted to give resident #023 the correct prescribed medications but the resident refused to take them indicating that he/she had already received pills. RN indicated that once the error was realized, he/she assessed the resident and monitored him/her for the remainder of the shift. RN indicated that he/she completed a medication error report and notified the oncoming shift of the error. RN #102 indicated that he/she did not notify the physician that resident #023 had received specified medications without an order. RN #102 indicated that he/she has received training on medication administration and incident reporting and is aware of the requirements when an error occurs.

The licensee failed to ensure that no drug is used or administered to a resident in the home unless the drug has been prescribed for the resident. [s. 131. (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 by ensuring that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #7: 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).

Findings/Faits saillants :

1. The licensee has failed 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?

Review of the progress notes for resident #023 indicated that on a specific date and time a medication incident occurred. The progress note indicated that RN #102 administered resident #024's medication to resident #023 in error. When RN tried to give resident #023 the actual scheduled medication the resident refused. A Medication Incident Report was filled out and resident #023 was monitored, no adverse effects noted.

There is no further documentation in resident #023's electronic records regarding the medication error or followup.

September 6, 2017, during an interview the Director of Care (DOC) indicated that there has been no medication errors in the home in June, July or August 2017.

During an interview September 7, 2017, RN #102 indicated that on a specified date, he/she was working the night shift. RN indicated that at a specific time he/she pre-poured the medications in the med room for resident #023 and #024. RN indicated that he/she

administered resident #024's medications to resident #023. He/she signed the eMAR as given and then realized that he/she had administered the wrong medications to resident #023. RN indicated that he/she attempted to give resident #023 the correct prescribed medications but the resident refused to take them indicating that he/she had already received pills. RN indicated that once the error was realized, he/she took resident's vital signs and monitored him/her for the remainder of the shift. RN indicated that he/she completed a medication error report and notified the oncoming shift of the error. RN #102 indicated that he/she did not notify the physician to inform that resident #023 had received medications that were not prescribed and to seek direction. RN indicated that he/she requested that the next shift contact the SDM and the doctor because it was too early in the morning to call them. RN indicated that he/she did not notify the pharmacy of the error. RN indicated that he/she placed the medication incident report on the DOC's desk. RN #102 indicated that he/she has received training on medication administration and incident reporting and is aware of the requirements when an error occurs.

September 7, 2017, during an interview the DOC indicated he/she was not aware of the medication error that occurred on a specific date, when resident #023 received resident #024's medications. The DOC indicated that he/she did not receive the medication error report from RN #102. The DOC indicated that the expectation is that when a medication error occurs the RN or RPN is required to complete a Medication Incident Report. The error is required to be reported to the SDM, the DOC, the physician and the pharmacy. The DOC indicated that documentation is also required to be completed in the resident's electronic chart which will include an assessment of the resident, immediate actions taken as well as notification of the physician, the pharmacy and the SDM. The DOC indicated that the documentation for resident #023 does not indicate that the SDM, physician or pharmacy were notified of the medication incident.

The licensee failed to ensure that resident #023's SDM, 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 were notified when a medication incident occurred on a specific date and time when resident #023 received medications that were prescribed for resident #024. [s. 135. (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 ensuring that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and 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 be implemented voluntarily.

Issued on this 26th day of October, 2017

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

Original report signed by the inspector.