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 18, 2018	2018_617148_0025	021696-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Religious Hospitallers of St. Joseph of Cornwall, Ontario
14 York St CORNWALL ON K6J 5T2

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

St. Joseph's Continuing Care Centre
14 York Street CORNWALL ON K6J 5T2

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

AMANDA NIXON (148), JANET MCPARLAND (142)

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): August 27, 28 , 29 and 30 and September 4, 5, 6, 7 and 11, 2018.

This inspection included four critical incident reports: Log 017226-18 related to improper/incompetent treatment of a resident that resulted in harm or risk of harm to a resident; Log 006301-18 related to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status; Log 006296-18 related to suspected visitor to resident abuse that resulted in harm or risk of harm to the resident; and Log 007671-18 related to the suspected misuse/misappropriation of residents money.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Nursing Care Coordinator, RAI Coordinator, Director of Information Systems, Director of Support Services, Resident and Family Advisor, Scheduler, Registered Nurses (RN), Registered Practical Nurses (RPN), Health Care Aids (HCA), family members and residents.

The Inspector(s) reviewed resident health care records, documents related to the medication management system, resident council meeting minutes and policies and procedures as required. In addition, the Inspectors toured resident care areas in the home and observed infection control practices, medication administration, staff to resident interactions and resident to resident interactions

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

5 WN(s)
1 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

The licensee has failed 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; that the care set out in the plan of care is provided to the resident as specified in the plan; and that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary.

Resident #028 requires oxygen therapy due to chronic disease and was described by the plan of care as oxygen dependent. As described by the plan of care and staff interviews, the HCAs are responsible for the application of oxygen therapy to residents.

A critical incident report was submitted to the Director on a specified date, describing that on the day previous at approximately 1950 hours, resident #028 was found in the resident's room with a portable oxygen tank applied and was reported to be in distress; the portable tank was found to be empty. Upon assessment by RN #123, the resident

was found to have oxygen saturation levels below baseline. The progress note written by RN #123 on the date of the incident, describes that HCA #118 reported filling up the portable tank approximately three hours prior to the incident. The resident was provided immediate treatment which included being placed on the room concentrator with oxygen therapy applied.

The plan of care for resident #028, in place at the time of the incident, indicated that the resident was to have the portable oxygen tank filled every two hours and to switch resident #028 from the portable tank to the room ventilator (concentrator) while in the resident's bedroom. The plan of care specifically directed that the portable tank was to be used when the resident was away from the resident's room only.

The Inspector spoke with HCA #118 who confirmed that on the identified date, the portable tank was last filled at approximately 1630 hours prior to the incident, when the resident was being assisted to the dining room. HCA #118 described that at approximately 1815 hours, the HCA observed resident #028 to be in the hallway speaking with a co-resident after having self-propelled from the dining room. HCA #118 assisted resident #028 to the resident's bedroom. HCA #118 reported awareness that the resident was to be on the room concentrator when in the resident's room. HCA #118 reported that it was HCA #118's understanding that one of the HCA's assigned to the resident would ensure that the resident was switched to the room concentrator. HCA #118 indicated that bathing was the primary assignment for HCA #118 and that resident #029 was not assigned to HCA #118.

On a specified date, resident #028 was not provided with oxygen therapy as set out by the plan of care, in that the resident was not switched to the room concentrator after having been assisted back to the resident's room and the portable tank was not filled every two hours as set out, which resulted in harm to resident #028.

The plan of care for resident #028 from early 2018 to September 6, 2018, also provided direction with regards to the flow rate of oxygen therapy, identifying a specific flow rate to be applied. The same direction was indicated by the physician order for the same period of time. The most recent oxygen therapy assessment dated early 2018, indicated similar direction for the application of oxygen therapy. On the morning of September 6, 2018, the Inspector observed the resident in the resident's room seated in a comfortable chair with the room concentrator applied; the concentrator was not set at the assessed flow rate.

On September 6, 2018, the Inspector spoke with HCA #116 who reported that resident #028 was provided with oxygen therapy via the portable tank or room concentrator at a specified rate that did not match the assessed flow rate. When asked where the HCA would be directed in the application of oxygen therapy to the resident, the HCA indicated that the plan of care would be the primary reference. HCA #116 then reviewed the plan of care and discovered that the flow rate was different than the flow rate that had been applied to the resident. In discussion, HCA #116 could not recall where it had been communicated that the resident required the specified flow rate that HCA #116 would regularly apply.

On the same date, the variance between the plan of care and the oxygen therapy applied was discussed with RPN #117, who reviewed the inactive file for the resident and found an assessment dated in late 2017. This assessment indicated that the flow rate had been previously higher than that indicated by the most recent assessment and plan of care. RPN #117 suspected that this may be why staff continued to apply oxygen at a different rate. When discussed with RPN #117, the RPN was unable to describe specific components of the plan of care with regards to the application of a higher level of flow rate, noting that the activity level of resident #028 had changed over time. RPN #117 noted that the direction for oxygen therapy was not clear for resident #028 and that oxygen therapy required reassessment.

After the Inspectors interaction with staff as above, resident #028 was reassessed for oxygen therapy. The assessment indicated that staff were unsure of which flow rate to use. The assessment recommended a specified flow rate, due to changes in the resident activity level and that the resident was known to retain carbon dioxide with recent complaints of light headedness and headaches. The plan of care was updated on the same day to reflect this assessment.

On September 11, 2018, during observations in the dining room, the Inspector observed the portable tank of resident #028 to not be set at the assessed flow rate. Upon interview, HCA #116 identified one rate flow for the resident and HCA #124 identified a different rate of flow for the resident.

During a review of resident #028's health care record, the Inspector noted oxygen saturation levels documented below baseline on a specified date during the evening shift. A progress note written by RPN #119 indicated that the resident was observed in the dining room exhibiting signs of confusion. The RPN noted the portable oxygen tank to be empty. The resident was returned to the resident's room and the room concentrator was

applied, the resident's oxygen level later returned to baseline. The Inspector spoke with RPN #119, who recalled the incident and care given but was not able to provide further detail on why the portable tank was found empty. The Inspector spoke with HCA#122 who had documented on the date of the incident, that the portable tank was filled at 1700 and 1800 hours. HCA #122 had no recollection of an incident involving an empty portable tank for this resident. The HCA reported that care for resident #028 included filling the portable oxygen tank just prior to the supper meal service which started at 1700 hours; this would be done by the HCA who assisted the resident to the dining room. HCA #122 said that the resident's tank is not filled at 1800 hours as the resident is generally taken back to the resident's room between 1800-1830 hours and placed on the room concentrator with no need to refill the portable tank.

Resident #028 was not provided with oxygen therapy as set out by the plan of care, on August 8, 2018 and September 6 and 11, 2018. On the morning of September 6, 2018, the plan of care for resident #026 did not provide for clear directions to staff in the application of oxygen therapy nor was the resident provided reassessment when the resident's care needs changed, specifically as it related to the application of flow rate for ambulation/exertion.

On the morning of September 7, 2018, the Inspector observed two additional residents with requirements for oxygen therapy; resident #029 and #030.

Resident #029 was observed in bed sleeping with oxygen therapy applied via the room concentrator which was set at an identified flow rate. The health care record of resident #029, indicated a physician order for the application of oxygen therapy at a different rate then that observed by the Inspector. The most recent oxygen therapy assessment indicated the resident requires the observed flow rate. When discussed with RPN #115, the RPN reported that there is not usually a physician order for oxygen therapy and that the oxygen therapy assessment would be the direction used by staff in the application of oxygen therapy. In discussion with HCA #116 and HCA #114, it was identified that the plan of care and/or registered nursing staff would be referenced for the application of a resident's oxygen therapy. The plan of care at the time of the Inspector's observation, directed staff to provide oxygen therapy as ordered by the medical doctor. HCA#114, reported that resident #029 requires the rate indicated by the physician order.

Resident #030 was observed in bed sleeping with oxygen therapy applied via the room ventilator which was set at an identified flow rate. A label on the ventilator of resident #030 stated a different flow rate.

The health care record of resident #030 was reviewed and did not have a physician order for oxygen therapy. The plan of care for resident #030 directs staff to provide oxygen therapy as ordered by the medical doctor. The most recent oxygen therapy assessment indicated the resident requires a flow rate at a different rate then that observed by the Inspector. In an interview with HCA #114, it was reported that resident #030 requires a different flow rate than that observed to be applied or as indicated by the assessment.

On September 11, 2018, the Inspector reviewed the plans of care for both resident #029 and #030 and observed that both the physician orders and plans of care had been updated to direct staff to provide resident #029 and resident #030 with an identified flow rate. The Inspector observed both residents and found resident #029 to be seated in a wheelchair in the resident's bedroom with the portable tank applied at half the rate indicated by the updated physician order and plan of care. HCA #124 who was present at the time of the observation reported that HCA #124 had understood that the resident was to be set at a different rate than observed or indicated by the physician order or plan of care.

The plans of care for resident #029 and #030, did not provide for clear direction whereby the residents were not provided with oxygen therapy as indicated by the most recent assessments. In addition, on September 11, 2018 resident #029 was not provided with oxygen therapy as set out by the plan of care.
(Log 017226-18)

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

As described in WN #1, the plan of care for resident #028 was not provided as set out on a specified date, in that the resident was not switched to the room concentrator after having been assisted back to the resident's room. The resident was found with the portable oxygen tank empty and the portable tank was not filled every two hours as set out, which resulted in harm to resident #028.

The Inspector spoke with RN #123, who stated that RN #123 had reported the incident to the home's DOC, although unsure of the date the report was made to the DOC. The RN indicated that the incident may be neglect or improper care and for this reason the DOC was contacted.

In a discussion with the DOC who reported the incident to the Director as improper or incompetent care the day after the incident, the DOC indicated that given the concerns of the family and that the plan of care was not provided to the resident, the DOC decided to make the report to the Director, when the DOC became aware of the incident.

As described in WN #1, the plan of care for resident #028 was not provided as set out on a specified date, in that the resident was found with an empty portable oxygen tank which resulted in harm to resident #028.

The Inspector spoke with RPN #119, who reported that at the time of the incident the filling of the portable tank may have been over looked or forgotten by HCA staff. When asked, RPN #119 reported that RPN #119 did not believe the tank was left empty on purpose and did not identify the incident as improper or incompetent care.

The home's DOC was made aware of this incident by the Inspector on September 7, 2018. On September 11, 2018, the DOC reported that the incident was reviewed but that it was not clear how or why the portable tank became empty.

The licensee did not report immediately the suspicion of improper or incompetent care on two separate occasions involving resident #028

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #023 began to exhibit altered skin integrity on a specified date in late 2017, which included an open area on an identified area of the body. The progress note indicating the first date of the wound, described the wound as ulcerated. Progress notes between this date and the spring of 2018 describe cleansing of the wound and application of antiseptic solution. Skin Monitoring Tools were completed monthly and describe either a pressure wound or open skin area; in the summer of 2018 a Skin Monitoring Tool denotes no skin breakdown.

In discussion with the home's Director of Care, Nursing Care Coordinator and Charge RN #105, the expectation is for registered nursing staff to conduct an initial assessment of a new wound and weekly assessments thereafter using the electronic assessment tool, titled Wound – Weekly Observation Tool. The Nursing Care Coordinator and Charge RN #105 reported that the skin wound described for resident #023 would require weekly assessment.

In review of the health care record there had been no skin assessment completed by a member of the registered nursing staff using a clinically appropriate assessment instrument. Further to this, over the period of time identified, there was no documentation to support that the wound was assessed at least weekly by a member of the registered nursing staff.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #025's physician orders and electronic medication administration record were reviewed for a specified month and indicated the resident was ordered to receive a pain medication three times daily.

On a specified date an incident report identified that resident #025 was not administered the pain medication. The resident sustained no untoward effects as a result of the error.

In an interview on August 29, 2018 with the Nursing Care Co-ordinator, it was confirmed that resident #025 was not administered three doses of pain medication on an identified date, as prescribed by the physician.

WN #5: 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 :

The licensee has failed to ensure that every medication incident involving a resident is reported to the resident, the resident's Substitute Decision Maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Resident #025's physician orders and electronic medication administration record were reviewed for a specified month and indicated the resident was ordered to receive a pain medication three times daily.
On a specified date an incident report identified that resident #025 was not administered the pain medication. The resident sustained no untoward effects as a result of the error. The medication incident report and the resident's health record were reviewed and it was noted that the medication incident was not reported to the resident, the resident's SDM or the resident's physician.

In an interview on August 29, 2018 with the Nursing Care Co-ordinator, it was confirmed that resident #025, the SDM and physician were not notified of the medication incident.

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

Issued on this 23rd day of October, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA NIXON (148), JANET MCPARLAND (142)
Inspection No. / No de l'inspection :	2018_617148_0025
Log No. / No de registre :	021696-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 18, 2018
Licensee / Titulaire de permis :	The Religious Hospitallers of St. Joseph of Cornwall, Ontario 14 York St, CORNWALL, ON, K6J-5T2
LTC Home / Foyer de SLD :	St. Joseph's Continuing Care Centre 14 York Street, CORNWALL, ON, K6J-5T2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gizanne Lafrance-Allaire

To The Religious Hospitallers of St. Joseph of Cornwall, Ontario, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, s.6
Specifically the licensee shall:
a) Ensure that residents #028, #029, #030 and any other resident are provided with oxygen therapy as indicated by the resident's assessed need and that staff who provided direct care are provided with clear directions in the application of the resident's oxygen therapy;
b) Upon being served with this Compliance Order and for 7 consecutive days, the licensee shall implement an enhanced monitoring process to be used by registered nursing staff responsible for the supervision of resident care to validate that all residents provided with oxygen therapy, including residents #028, #029 and #030, receive oxygen therapy as indicated by the resident's assessed need; and
c) Evidence of that enhanced monitoring process and the actions taken by registered nursing staff to address findings of non-compliance must be documented and submitted to the Director of Care at the end of every 24 hour period.

Grounds / Motifs :

1. The licensee has failed 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; that the care set out in the plan of care is provided to the resident as specified in the plan; and that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary.

Specifically, the licensee did not ensure that resident #028, #029 and #030 had plans of care providing clear direction to staff on the application of oxygen therapy, oxygen therapy was not provided as set out by the plan of care and in the matter of resident #028 the plan of care was not reviewed and revised when the resident's care needs changed or when the care set out was no longer necessary.

Resident #028 requires oxygen therapy due to chronic disease and was described by the plan of care as oxygen dependent. As described by the plan of care and staff interviews, the HCAs are responsible for the application of oxygen therapy to residents.

A critical incident report was submitted to the Director on a specified date, describing that on the day previous at approximately 1950 hours, resident #028 was found in the resident's room with a portable oxygen tank applied and was reported to be in distress; the portable tank was found to be empty. Upon assessment by RN #123, the resident was found to have oxygen saturation levels below baseline. The progress note written by RN #123 on the date of the incident, describes that HCA #118 reported filling up the portable tank approximately three hours prior to the incident. The resident was provided immediate treatment which included being placed on the room concentrator with oxygen therapy applied.

The plan of care for resident #028, in place at the time of the incident, indicated that the resident was to have the portable oxygen tank filled every two hours and to switch resident #028 from the portable tank to the room ventilator (concentrator) while in the resident's bedroom. The plan of care specifically directed that the portable tank was to be used when the resident was away from the resident's room only.

The Inspector spoke with HCA #118 who confirmed that on the identified date, the portable tank was last filled at approximately 1630 hours prior to the incident, when the resident was being assisted to the dining room. HCA #118 described that at approximately 1815 hours, the HCA observed resident #028 to be in the hallway speaking with a co-resident after having self-propelled from the dining room. HCA #118 assisted resident #028 to the resident's bedroom. HCA #118 reported awareness that the resident was to be on the room concentrator when in the resident's room. HCA #118 reported that it was HCA #118's

understanding that one of the HCA's assigned to the resident would ensure that the resident was switched to the room concentrator. HCA #118 indicated that bathing was the primary assignment for HCA #118 and that resident #029 was not assigned to HCA #118.

On a specified date, resident #028 was not provided with oxygen therapy as set out by the plan of care, in that the resident was not switched to the room concentrator after having been assisted back to the resident's room and the portable tank was not filled every two hours as set out, which resulted in harm to resident #028.

The plan of care for resident #028 from early 2018 to September 6, 2018, also provided direction with regards to the flow rate of oxygen therapy, identifying a specific flow rate to be applied. The same direction was indicated by the physician order for the same period of time. The most recent oxygen therapy assessment dated early 2018, indicated similar direction for the application of oxygen therapy. On the morning of September 6, 2018, the Inspector observed the resident in the resident's room seated in a comfortable chair with the room concentrator applied; the concentrator was not set at the assessed flow rate.

On September 6, 2018, the Inspector spoke with HCA #116 who reported that resident #028 was provided with oxygen therapy via the portable tank or room concentrator at a specified rate that did not match the assessed flow rate. When asked where the HCA would be directed in the application of oxygen therapy to the resident, the HCA indicated that the plan of care would be the primary reference. HCA #116 then reviewed the plan of care and discovered that the flow rate was different than the flow rate that had been applied to the resident. In discussion, HCA #116 could not recall where it had been communicated that the resident required the specified flow rate that HCA #116 would regularly apply.

On the same date, the variance between the plan of care and the oxygen therapy applied was discussed with RPN #117, who reviewed the inactive file for the resident and found an assessment dated in late 2017. This assessment indicated that the flow rate had been previously higher than that indicated by the most recent assessment and plan of care. RPN #117 suspected that this may be why staff continued to apply oxygen at a different rate. When discussed with RPN #117, the RPN was unable to describe specific components of the plan of care with regards to the application of a higher level of flow rate, noting that the activity level of resident #028 had changed over time. RPN #117 noted that the

direction for oxygen therapy was not clear for resident #028 and that oxygen therapy required reassessment.

After the Inspectors interaction with staff as above, resident #028 was reassessed for oxygen therapy. The assessment indicated that staff were unsure of which flow rate to use. The assessment recommended a specified flow rate, due to changes in the resident activity level and that the resident was known to retain carbon dioxide with recent complaints of light headedness and headaches. The plan of care was updated on the same day to reflect this assessment.

On September 11, 2018, during observations in the dining room, the Inspector observed the portable tank of resident #028 to not be set at the assessed flow rate. Upon interview, HCA #116 identified one rate flow for the resident and HCA #124 identified a different rate of flow for the resident.

During a review of resident #028's health care record, the Inspector noted oxygen saturation levels documented below baseline on a specified date during the evening shift. A progress note written by RPN #119 indicated that the resident was observed in the dining room exhibiting signs of confusion. The RPN noted the portable oxygen tank to be empty. The resident was returned to the resident's room and the room concentrator was applied, the resident's oxygen level later returned to baseline. The Inspector spoke with RPN #119, who recalled the incident and care given but was not able to provide further detail on why the portable tank was found empty. The Inspector spoke with HCA #122 who had documented on the date of the incident, that the portable tank was filled at 1700 and 1800 hours. HCA #122 had no recollection of an incident involving an empty portable tank for this resident. The HCA reported that care for resident #028 included filling the portable oxygen tank just prior to the supper meal service which started at 1700 hours; this would be done by the HCA who assisted the resident to the dining room. HCA #122 said that the resident's tank is not filled at 1800 hours as the resident is generally taken back to the resident's room between 1800-1830 hours and placed on the room concentrator with no need to refill the portable tank.

Resident #028 was not provided with oxygen therapy as set out by the plan of care, on August 8, 2018 and September 6 and 11, 2018. On the morning of September 6, 2018, the plan of care for resident #026 did not provide for clear directions to staff in the application of oxygen therapy nor was the resident

provided reassessment when the resident's care needs changed, specifically as it related to the application of flow rate for ambulation/exertion.

On the morning of September 7, 2018, the Inspector observed two additional residents with requirements for oxygen therapy; resident #029 and #030.

Resident #029 was observed in bed sleeping with oxygen therapy applied via the room concentrator which was set at an identified flow rate. The health care record of resident #029, indicated a physician order for the application of oxygen therapy at a different rate then that observed by the Inspector. The most recent oxygen therapy assessment indicated the resident requires the observed flow rate. When discussed with RPN #115, the RPN reported that there is not usually a physician order for oxygen therapy and that the oxygen therapy assessment would be the direction used by staff in the application of oxygen therapy. In discussion with HCA #116 and HCA #114, it was identified that the plan of care and/or registered nursing staff would be referenced for the application of a resident's oxygen therapy. The plan of care at the time of the Inspector's observation, directed staff to provide oxygen therapy as ordered by the medical doctor. HCA #114, reported that resident #029 requires the rate indicated by the physician order.

Resident #030 was observed in bed sleeping with oxygen therapy applied via the room ventilator which was set at an identified flow rate. A label on the ventilator of resident #030 stated a different flow rate.

The health care record of resident #030 was reviewed and did not have a physician order for oxygen therapy. The plan of care for resident #030 directs staff to provide oxygen therapy as ordered by the medical doctor. The most recent oxygen therapy assessment indicated the resident requires a flow rate at a different rate then that observed by the Inspector. In an interview with HCA #114, it was reported that resident #030 requires a different flow rate than that observed to be applied or as indicated by the assessment.

On September 11, 2018, the Inspector reviewed the plans of care for both resident #029 and #030 and observed that both the physician orders and plans of care had been updated to direct staff to provide resident #029 and resident #030 with an identified flow rate. The Inspector observed both residents and found resident #029 to be seated in a wheelchair in the resident's bedroom with the portable tank applied at half the rate indicated by the updated physician

order and plan of care. HCA #124 who was present at the time of the observation reported that HCA #124 had understood that the resident was to be set at a different rate than observed or indicated by the physician order or plan of care.

The plans of care for resident #029 and #030, did not provide for clear direction whereby the residents were not provided with oxygen therapy as indicated by the most recent assessments. In addition, on September 11, 2018 resident #029 was not provided with oxygen therapy as set out by the plan of care.
(Log 017226-18)

The severity of this issue was determined to be a level 3 as there was actual harm to resident #028. The scope of the issue was a level 3, indicating wide spread, as non-compliance related to oxygen therapy was found with each resident identified. The compliance history is a level 3 as non-compliance with this section of the LTCHA, 2007 has been issued as follows:
- Voluntary Plan of Correction issued November 8, 2017 (2017_683126_0017)
- Written Notification issued September 15, 2017 (2017_683126_0011)
- Voluntary Plan of Correction issued July 18, 2016 (2016_381592_0016)
- Voluntary Plan of Correction issued February 19, 2016 (2016_381592_0005)
- Voluntary Plan of Correction issued January 5, 2016 (2015_347197_0039)

(148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 18, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 18th day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : AMANDA NIXON

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