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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 07, 2018;	2017_695156_0007 (A1)	025636-17	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

DUNDURN PLACE CARE CENTRE
39 MARY STREET HAMILTON ON L8R 3L8

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

CAROL POLCZ (156) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

"Revision to compliance order #002"

Issued on this 7 day of February 2018 (A1)

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

Original report signed by the inspector.

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 prévue le Loi de 2007 les foyers de soins de longue durée

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CAROL POLCZ (156) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): November 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 29, 30, 2017.

During this inspection the inspections listed below were conducted concurrently:

Follow ups:

Order #1 related to abuse and neglect

Order #2 related to responsive behaviours

Order #3 related to responsive behaviours

Critical Incidents:

CIS 13793-17 related to abuse and neglect

CIS17059-16 related to abuse and neglect

CIS 20601-16 related to abuse and neglect

CIS 31808-16 related to resident elopement

CIS 23440-17 related to unexpected death

CIS 25511-17 related to abuse and neglect

Complaints:

Complaint 16846-16 related to abuse and neglect, environmental concerns

Complaint 6864-17 related to abuse and neglect

Complaint 11432-17 related to pain management

Complaint 15492-17 related to abuse and neglect

Complaint 18425-17 related to abuse and neglect

During the course of the inspection, the inspector(s) spoke with Administrator, Directors of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument Co-ordinator (RAI), registered nurses (RNs), registered practical nurses (RPNs), wound care nurse, nurse Manager, Maintenance Lead, Staff Educator, Social Worker, Business Manager, Hairdresser, Pain Committee Lead, Recreational Therapist, Recreation Manager, restorative care aides, Quality Improvement Coordinator, housekeepers, Personal Support Workers (PSWs), food service workers, residents and families.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, observed medication passes, reviewed clinical records, policies and procedures, the home's complaints process, investigative notes and conducted interviews.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

- **12 WN(s)**
- **8 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 54.	CO #003	2017_587129_0007	506

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the pain management program to identify pain in residents and manage pain was developed and implemented in the home.

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

participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

At the time of the inspection, the pain management program was not developed and implemented in the home.
• The home failed to provide a written description of the program that included the goals and objectives.
• Polices and procedures provided by the home were outdated.
A) The Pain Management Policy Appendix VII indicated that residents on scheduled pain management medications would have a weekly summary completed, which evaluated pain control measures and effectiveness of medication. The Pain management lead reported that this policy was no longer current and that the home completed a monthly pain evaluation summary.
B) Another pain management policy by the same name provided by the home indicated that resident on scheduled pain management mediations would have a monthly evaluation summary completed which evaluated pain control measures and effectiveness of pain medications. This summary was not found to be completed for the month of October, 2017 for resident #031. There was no policy on how to complete the monthly evaluation summaries and were found to contain data but not an evaluation of pain management for resident #031.
C) The policies provided indicated that referrals to other disciplines were made as needed, however, did not indicate the protocol to do so.
D) There was no policy in regards to the administration and evaluation of PRN medication. See findings documented under O. Reg. 79/10 s. 134 (a).
E) Interview with the pain committee lead on November 22, 2017 reported that they use a "three on three" approach with regards to PRN medication. This approach means that if a resident was administered a PRN medication three times in one day or three days in a row, they would notify the physician. As confirmed with the pain management lead as well as DOC #10.
• The annual program evaluation provided by the home dated April 11, 2017 contradicted what staff had provided to the inspector. The evaluation indicated "yes" that the home had a formalized pain management program that included written program description, goals and objectives, relevant policies and procedures, protocols and methods to reduce risk, tracking tools that monitor outcomes and protocols for referrals to specialized resources where required which were not provided at the time of the inspection. Interview with the Quality Improvement Coordinator confirmed that the evaluation did not provide those items listed above. It was also confirmed that the evaluation did not include a summary of the changes made and the date that those changes were implemented.

• The program did not identify pain management in resident #031. Resident #031 was noted to have ‘as needed’ (PRN) pain medications administered multiple times over several months in addition to regularly scheduled pain medications; however, the use of the regularly scheduled medications in relation to the use of PRN medications was not evaluated.
• The program did not identify pain management in resident #032. Resident #032 was noted to have PRN pain medication administered in November, 2017, however, the medication was ineffective and the resident's pain increased. Alternate PRN pain medication was not administered and the resident’s pain was not reassessed when their care needs had changed in relation to pain.

An organized program for pain management was not developed and implemented in the home as confirmed with the Administrator, DOC #101 and DOC #103. [s. 48. (1) 4.]

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. In accordance with Ontario Regulation 79/10, s. 2 (1) physical abuse is defined as “the use of physical force by a resident that causes injury to another resident”.

A) The licensee failed to protect resident #042 from physical abuse by co-resident #041.
Resident #042, DOC #101 and clinical documentation confirmed that on an identified date in November, 2017, resident #042 was physically abused by co-resident #041. As a result of the actions of the co-resident, resident #042 sustained an injury. Resident #041 was able to recall the incident at the time of this inspection. Resident #042 confirmed that they have no idea why the co-resident attacked them. Clinical documentation confirmed that the day following the incident registered staff became concerned about the injuries and transferred the resident to hospital. The resident returned to the home.
The clinical record indicated that resident #041 had demonstrated physically aggressive behaviour towards co-residents on identified dates in April and March, 2017, November and August, 2016 prior to the incident noted above in November, 2017.

B) The licensee failed to protect resident #038 from physical abuse by co-resident #037.
On an identified date in July, 2016, resident #037 and co-resident #038 were in an altercation. Resident #038 complained of pain and the resident was sent to the hospital. The resident returned to the home. In an interview with resident #038, the resident could recall the incident and confirmed that they stay away from the resident and still fear for their safety around resident #037. [s. 19. (1)]

2. In accordance with Ontario Regulation 79/10, s. 2 (1) sexual abuse is defined as "any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a licensee or staff member".

C) The licensee failed to protect resident #035 from sexual abuse by a staff member.
On an identified date in May, 2016, resident #035 reported to PSW #117 that PSW #116 touched them inappropriately. Review of the home's investigation notes confirmed that PSW #116 sexually abused resident #035 and this was confirmed with the Administrator. An interview with resident #035, confirmed that they still recall the incident and they felt betrayed and not safe at the time of the incident. The licensee failed to ensure that resident #035 was protected from sexual abuse.

Note: there was an outstanding order at the time and the compliance due date had

not passed at the time the incidents in B) and C) occurred. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that written approaches to care as well as resident monitoring an internal reporting protocols were developed to meet the needs of the residents with responsive behaviours.

The licensee failed to comply with the following activities that the home was ordered to complete as part of the compliance order for O. Reg. 79/10, s. 53 (1) served on August 16, 2017. The compliance order was to be complied by October 16, 2017.

1. The licensee was to develop and implement a policy, procedure and tool to be used when attempting to identify possible triggers for responsive behaviours being demonstrated by residents.
An interview with the Staff Educator on November 21, 2017, confirmed that tool was being piloted in the home and the final version of the responsive behaviour debrief tool was not given to the home until the end of October, 2017. In an interview with DOC on November 17, 2017, confirmed that the home did not have a policy or procedure for the responsive behaviour debrief tool and that the staff had not been trained on this tool. The home produced a procedure for the responsive behaviour debrief tool on November 20, 2017 and confirmed that this is the first time the home was given the procedure for how to use the responsive behaviour debrief tool.
2. The licensee was to provide face to face training for all staff related to the implementation of the above noted tool. The home is to maintain specific subject matter an attendance records for this training.
An interview with the staff Educator and DOC #103 confirmed on November 21, 2017, that only three registered staff out of fifty-five had been trained on the use of the tool because the home did not have the final version of the tool available as well as a policy and procedure in place to educate and implement the tool.
3. The licensee was to implement the above noted tool and reassess all residents who demonstrate responsive behaviours for possible triggers for each responsive behaviour demonstrated. Plans of Care are to be developed, implemented and evaluated related to the management of identified behavioural triggers.
An interview with the MDS RAI co-ordinator on November 21, 2017, confirmed that the above noted tool was not implemented and residents who demonstrate responsive behaviours were reassessed.
4. Clinical records reviewed for resident #034 and resident #035 confirmed that these residents were identified to demonstrate responsive behaviours and there was no clinical documentation to indicate that an attempt to identify triggers for the specific behaviours being demonstrated by these residents were completed. DOC #101 confirmed that the home did complete the responsive behaviour debrief tool but did not identify the trigger for the responsive behaviour and there were no written approaches for staff to follow. [s. 53. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 :

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

Resident #044's plan of care did not provide clear directions to staff and others who provided direct care related to the use of a medical intervention. The clinical record indicated the use of the medical intervention was implemented in August 2016. DOC #101 and clinical documentation confirmed that although the Treatment Administration Record (TAR) contained a schedule for registered staff to address the medical intervention, there were no clear directions in the document direct care staff used to identify the care to be provided to the resident. DOC #101 and clinical documentation confirmed that the document staff in the home use to direct the care of the resident did not contain directions for Personal Support Workers related to the location of the medical intervention or care consideration to be implemented when staff assisted the resident with activities of daily living. The above noted document also did not provide directions to registered staff related to safety and infection control considerations for this resident.
Resident #044's plan of care did not provide clear directions to staff and others who provided direct care to the resident in relation to the use of the identified medical intervention. [s. 6. (1) (c)]

2. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #048 was capable of making their own decisions regarding their care, however had expressed that they wanted their family to be notified with any changes in their condition.
Resident #048's plan of care and on their profile page, clearly indicated that the family was to be called for any status changes in the resident.
i) On an identified date in March, 2017, resident #048 went to the hospital and the home did not notify the resident's family of the transfer until the home was notified that the resident would be returning to the home.
ii) On an identified date in July, 2017, resident #048 went to the hospital while out of the home and the home was informed of the resident's transfer to the hospital.

The resident returned from the hospital later that day and the home did not inform the family of the resident’s transfer to the hospital.
iii) On an identified date in August, 2017, the resident returned from a doctors appointment with a medical intervention and new orders. The family was not notified of the hospital visit or orders by the home but by an external agency.
iv) On an identified date in September, 2017, the resident requested to go to the hospital as they had pain. The resident went to the hospital and returned back home after having a treatment and the family was not called.

DOC #101 confirmed that the resident and the resident's family wishes were not followed and they were not given the opportunity to participate fully in the development and the implementation of the resident's plan of care. [s. 6. (5)]

3. Resident #044 did not receive care as specified in the plan of care related to the procedure for an identified medical intervention used to administer medications to the resident. DOC #101 and clinical documentation confirmed that directions for the medical intervention specified in the Treatment Administration Record (TAR), were not completed as specified. Clinical documentation indicated that staff had not signed the TAR on two identified dates in February, 2017, to indicate that the treatment had been completed as specified in the TAR. DOC #101 indicated that it was the expectation that staff would document that this care was provided both in the TAR as well as in a progress note and confirmed that it was their position that if care for the resident has not been documented the care had not been provided. Resident #044 did not receive care as specified in the resident’s plan of care related to the maintenance of an identified medical intervention. [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs had changed or care set out in the plan was no longer necessary.

Resident #032 was admitted to the home in 2017 with an order for pain medication A to be given up four times daily when needed, medication B to be given every four hours for pain/fever and medication C every four hours as needed (PRN) for pain. On an identified date in November, 2017 at an identified time, a review of the clinical record indicated that the resident appeared uncomfortable, and staff were unable to get a pain level due to cognitive decline. The Pain Assessment in Advanced Dementia (PAINAD) scale which the home used to determine pain level in the cognitively impaired identified the resident’s pain to be on the low end of the

scale. The resident was administered medication C. Approximately one hour and twenty minutes later, the PRN administration was noted to be ineffective and the resident continued to display responsive behaviours. Pain was noted to be a trigger for these behaviours. There was no evidence to support that the resident was reassessed for pain until the following day when, at an identified time it was noted that the resident was still experiencing pain. The pain had increased on the PAINAD scale. The resident was administered medication C for comfort to help with pain. Approximately three hours later, it was noted that the resident continued to display behavioural symptoms and the PRN administration was deemed to be ineffective. Although there was an order for PRN medication A, it was not administered, the physician was not contacted and no further assessment or interventions to relieve the resident's pain were completed until approximately one hour and fifty minutes later when another dose of medication C was administered. This dose was deemed effective as of the progress note from one hour post administration.
Over the next few days, the resident continued to experience pain and the medication C dose was increased every six hours as scheduled on an identified date in November, 2017.
The plan of care since admission indicated that the resident's pain was managed with PRN analgesic.
The plan of care was not updated when the resident continued to experience pain and was ordered a regularly scheduled dose of pain medication.
There was no pain assessment completed when the resident's care needs had changed in relation to pain.
The resident was not reassessed and the plan of care reviewed and revised when the resident's care needs had changed as confirmed with DOC #103 on November 28, 2017. [s. 6. (10) (b)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the care set out in the plan of care was not effective.

Resident #049's plan of care was not reviewed or revised when the resident continued to wander from an identified floor and elope from the building. When the resident was admitted to the home in 2015 the resident was identified as being independently ambulatory, at risk for wandering as well as elopement and was assessed as requiring the use of an identified intervention.
1. DOC #103, clinical documentation and risk documents maintained in the home confirmed that resident #049 left the home on an identified date in August, 2016.

Staff located the resident and the resident returned to the home. Clinical documentation indicated staff in the home were unsure how long the resident remained outside the home and that the intervention was not effective at the time of elopement.
DOC #103 and clinical documentation confirmed that the plan of care was not reviewed or revised when the care identified on an identified date in January, 2015, related to exit seeking and wandering behaviours had not been effective in preventing the resident from wandering or reduce the risk of elopement. Staff in the home did not revise the resident's plan of care when they became aware of the ineffectiveness of the intervention.
2. DOC #103, clinical documentation and risk management documents maintained by the home confirmed that resident #049 left the home on an identified date in October, 2016, and was found a significant distance away from the home the police were contacted and returned the resident to the home after being away from the home an estimated period of five and a half hours.
Information provided to the Ministry of Health and Long Term Care (MOHLTC) in a Critical Incident Report (CIR) indicated that the resident did not have intervention in place in accordance with the resident's plan of care.
DOC #103 and clinical documentation confirmed that the plan of care was not reviewed or revised when the care identified in January, 2016 and July, 2016, had not been effective in preventing the resident from wandering or reduce the risk of elopement. Resident #049's plan of care was not reviewed or revised following the above noted incident when staff were aware the intervention was ineffective and the monitoring schedule put in place was not effective in preventing the resident from wandering and leaving the home.
3. DOC #103 and clinical documentation confirmed that on an identified date in October, 2016, resident #049 wandered off the floor two times and was located at the front door of the home attempting to leave the home. Staff escorted the resident back to the home area following this incident.
DOC #103 and clinical documentation confirmed that the resident's plan of care was not reviewed or revised when the care planned for the resident was not effective in preventing the resident from wandering off the floor which placed the resident at risk for elopement from the home.
4. DOC #103 and clinical documentation confirmed that on an identified date in October, 2016 the home received a call from an employee who saw the resident walking on a city street. Clinical documentation indicated when the resident was returned to the home the resident said they were very cold as they did not have a coat on while out of the home. The resident was taken to their home area, provided with a blanket and a warm drink. Staff also documented that staff were not alerted

to the fact that the resident had eloped and no staff were in noted to be the area when the resident was returned to the home area. DOC #103 and clinical documentation confirmed that the resident's plan of care was not reviewed or revised when the planned care for the resident was not effective in preventing the resident from wandering off the floor and leaving the home.
5. DOC #103 and clinical documentation confirmed that on an identified date in November, 2016, resident #049 was found attempting to leave the home. The resident was prevented from leaving the home by staff and returned to their home area.
DOC #013 and clinical documentation confirmed that the resident's plan of care was not reviewed or revised when the planned care for the resident was not effective in preventing the resident from wandering off the floor.
6. DOC #103 and clinical documentation confirmed that on an identified date in December, 2016, resident #049 was seen by two staff members to be walking up the stairs in the stairwell. The DOC confirmed that they were not aware how the resident entered the stairwell, the stairwell could be accessed only when a code was entered into a key pad and the door to the stairwell did not stay open when someone walked through the door.
DOC #103 and clinical documentation confirmed that the resident's plan of care was not reviewed or revised when the planned care for the resident was not effective in preventing the resident from being put at risk when they wandered off the floor and into a stairwell.

Staff and clinical documentation confirmed that over a five month period of time resident #049 wandered off the floor four times and eloped from the home on three occasions. DOC #103 confirmed that for each of the above noted incidents staff in the home were not aware of how the resident was able to wander from the floor or leave the home. DOC #103 and clinical documentation confirmed that the resident's plan of care was not reviewed or revised during the above noted period of time when the planned care for the resident had not been effective in preventing the resident from being put at risk when the resident wandered of the floor and left the home unescorted. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provide direct care to residents, to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given the opportunity to participate fully in the development and implementation of the resident's plan of care, to ensure that the resident received care as specified in the plan of care, to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs had changed or care set out in the plan was no longer necessary and to ensure that the resident was reassessed and the plan of care reviewed and revised when the care set out in the plan of care was not effective, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, in place in the home, was complied with.

The Licensee's policy “Abuse and Neglect Policy”, located in the Resident Rights section of the Resident Care and Services Manual, identified as RCS P-10 and last reviewed on July 2, 2015, directed:
1. The home will immediately investigate any allegations of harm or potential harm to a Resident, including as caused by abuse or neglect, and will therefore take all

appropriate actions.
2. Any alleged, suspected or witnessed incident of abuse or neglect of a resident is to be reported to the Administrator/designate of the home (the “Administrator”), who will immediately commence an investigation.
3. The Administrator or designate are to conduct the following parts of the investigation:
i) Assemble an investigative team
ii) Gather all relevant documents
iii) Conduct interviews
iv) Document interviews
v) Reach a decision
vi) Communicate the outcome

A) The licensee's policy was not complied with when the staff in the home failed to immediately conduct an investigation when the home became aware on an identified date in June, 2016, of an incident that occurred the previous day. On the above noted date a co-resident reported an incident where they observed resident #043 being treated roughly by staff #127. The home submitted information to MOHLTC which indicated that there was a witnessed incident of physical and emotional abuse of resident #043. Staff in the home failed to conduct interviews of the two witnesses identified in the Critical Incident Report submitted to MOHLTC. The Administrator confirmed that, at the time of this inspection, they were unable to produce any documentation to indicate they had interviewed all people who witnessed or had knowledge of the above noted incident, reached any decisions related to the incident or communicated they had reached any outcomes.
B) On an identified date in May, 2016, as per progress note by RPN #118, resident #035 expressed concerns to PSW #117 that PSW #116 had touched them inappropriately. A review of the investigation notes identified that DOC #101 and Administrator became aware of the incident the next morning when resident #035 reported the incident. Interview with DOC #101 on November 22, 2017, confirmed that RPN #118 did not follow the home's abuse policy and immediately advise the administrator/designate of the home of any suspected abuse of a resident. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, in place in the home, was complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated.

The licensee became aware on an identified date in June, 2016 of an incident that occurred the previous day, when a co-resident reported an incident where resident #043 was treated roughly by staff #127. The home submitted a Critical Incident Report (CIR) to the Ministry of Health and Long Term Care (MOHLTC) the following day and reported the incident as physical and emotional abuse of resident #043. The Administrator, DOC #101 and DOC #103 confirmed that they were unable to produce any records to verify that this incident was investigated. At the time of this inspection the Administrator indicated that the investigation was completed by the Recreation Manager and the Convalescent Care Manager. The only document the Recreation Manager was able to provide was a copy of an email sent to them by the Convalescent Care Manger that indicated that the resident was not able to communicate about the incident due to a medical condition, but indicated that by the resident's actions, the resident was upset.
The CIR indicated that an identified resident witnessed the incident and there was no indication that the resident identified on the CIR was interviewed about the incident. The CIR also indicated the incident was witnessed by another employee and there was no indication that the employee, who was not named in the CIR, was interviewed in relation to this incident of witnessed physical and emotional abuse of resident #043.
At the time of this inspection the home was unable to provide any documentation to verify that the incident of abuse witnessed in June, 2016, was investigated. [s. 23. (1) (a)]

Additional Required Actions:

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

WN #7: 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 :

1. The licensee failed to ensure that the resident who exhibited 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 was specifically designed for skin and wound assessment.

Resident #036 had areas of altered skin integrity. On an identified date in May, 2016, it was identified that the resident had two dressings on two different areas. A review of the clinical record did not include an assessment of the areas of altered skin integrity using a clinically appropriate assessment instrument when they were first identified. Four days later, the family of the resident was asking questions about the resident's multiple areas of altered skin integrity and at this time an assessment was also not completed of the identified areas. Interview with the home’s wound care nurse on November 22, 2017, confirmed that there was no initial assessment of the areas of altered skin integrity by a member of the registered nursing staff using a clinically appropriate assessment instrument as required. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who exhibited 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 was specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of housekeeping services, procedures were implemented for cleaning and disinfection of resident's personal assistance services devices.
Observations made by Long Term Care Home Inspector #129 and DOC #103 confirmed that resident #045, resident #046 and resident #047's wheelchairs were soiled with organic and inorganic matter.
RPN #107 confirmed that there was a schedule for the cleaning of wheelchairs posted at the nursing station and Personal Support Workers (PSW) who work during the night shift were responsible for cleaning resident's wheelchairs in accordance with the schedule.
The identified cleaning schedule indicated that five residents were to have their wheelchairs cleaned during the night shift on an identified date. Three of the five residents were noted by the Inspector and DOC #103 to have soiled wheelchairs the following day and DOC #103 confirmed that these wheelchairs had not been cleaned.
DOC #103 confirmed that staff were to initial a document to indicate that the residents' wheelchairs had been cleaned; however a review of the document indicated that staff had not signed the document to indicate the scheduled residents' wheelchairs had been cleaned on four identified dates in November, 2017
Staff in the home failed to implement the procedures for cleaning and disinfection of the residents' wheelchairs when they failed to implement the identified schedule. [s. 87. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that as part of the organized program of housekeeping services, procedures were implemented for cleaning and disinfection of resident's personal assistance services devices, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On an identified date in November, 2017, RPN #107 was giving medications to a resident down the hall. The LTCH Inspector was able to open to the medication cart and was able to access the narcotics from the controlled substance bin without unlocking the second lock on the bin. RPN #107 confirmed that the bin lid was not closed all the way and therefore the controlled substances were not double-locked while in the medication cart, as required. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that medications were stored in an area or a medication cart that was secured and locked.

On an identified date in November, 2017, the medication cart on the secured unit of the home was noted to be sitting in the hall way unlocked. RPN #107 was giving medications to a resident. The RPN's back was to the medication cart and was unaware that the LTC Homes Inspector was able to open and close medication cart drawers. When RPN #107 returned to the cart, they confirmed that the cart was not locked and secured when unattended. [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that medications were stored in an area or a medication cart that was secured and locked, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that for the resident taking any drug or combination of drugs, including psychotropic drugs, that there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Resident #031 had a physician’s order for regularly scheduled medication A, B, and C The resident also had a physician’s order for ‘as needed’ (PRN) medication C when needed and medication A when needed.
a) During the month of March, 2017, the resident received PRN medication A twice and medication C once.
b) During the month of April, 2017, the resident received PRN medication A seven times and medication C twelve times.
c) During the month of May, 2017, the resident received PRN medication A three times and medication C three times.
d) During the month of June, 2017, the resident received PRN medication A ten times and medication C eighteen times.
e) During the month of July, 2017, the resident received PRN medication A twelve times and medication C twenty-eight times.
f) During the month of August, 2017, the resident received PRN medication A five times and medication C fourteen times.
g) During the month of October, 2017, the resident received PRN medication A ten times and medication C thirteen times.
h) During the month of November, 2017 to date (November 23, 2017), the resident received PRN medication A once and medication C eight times.

DOC #101 and DOC #103 confirmed that the expectation of the home would be that the PRN medication be switched to a regularly scheduled dose when it was noted that there was an increased use of as necessary medication required by the resident. It was the expectation that the registered staff would refer to the physician to review the high use of PRN medication; however, as confirmed with DOC #101, there was no evidence to support that the use of PRN medication had been referred or reviewed by the physician or pharmacy.
Interview with DOC #101 and the Pain committee lead confirmed that the home completed a ‘pain evaluation summary’ on a monthly basis. It was confirmed that there was no evaluation of the effectiveness of the PRN medication in this

summary and that the home failed to complete the summary for resident #031 for the month of October, 2017.
At the time of the inspection, DOC #101, DOC #103, and the Pain committee lead were unable to provide evidence that the home had a policy or procedure in place to evaluate the overall pain management of resident #031 and the effectiveness of the regularly scheduled medications in relation to the use of PRN medications. Staff failed to evaluate the effectiveness of the medications to manage the resident’s pain when the record confirmed that resident was taking multiple PRN doses beyond the regularly scheduled doses for pain management. [s. 134. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for the resident taking any drug or combination of drugs, including psychotropic drugs, that there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
4. The licensee did not keep a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A review was completed of the skin and wound program evaluation. It was identified that the evaluation did not include the date the evaluation was completed. It was also noted, that the evaluations did not identify the dates that any changes were implemented. This was confirmed with the wound care nurse during an interview on November 23, 2017. [s. 30. (1) 4.]

Issued on this 7 day of February 2018 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
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Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l’inspecteur (No) : CAROL POLCZ (156) - (A1)

Inspection No. / No de l’inspection : 2017_695156_0007 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 025636-17 (A1)

Type of Inspection / Genre d’inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Feb 07, 2018;(A1)

Licensee / Titulaire de permis : RYKKA CARE CENTRES LP
3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2

LTC Home / Foyer de SLD : DUNDURN PLACE CARE CENTRE
39 MARY STREET, HAMILTON, ON, L8R-3L8

Name of Administrator / Nom de l’administratrice ou de l’administrateur : Leslie Watson

To RYKKA CARE CENTRES LP, 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 :

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

Order / Ordre :

1. The licensee shall ensure that a pain management program is developed and implemented in the home in accordance with s. 30 (1).

2. The licensee shall ensure that all residents, including resident #031 and #032's pain is managed.

3. The licensee is to develop and implement a mechanism to ensure that staff have quick and easy access to directions related to the pain management of residents as well as the licensee's policies and procedures.

4. The licensee is to provide training for all direct care staff related to the revised policies, procedures, pathways, tools and process for quick and easy access to information related to the management of pain of residents. All documentation related to the content of training programs provided and attendance at those programs is it to be maintained by the home.

5. The licensee will create an audit to ensure that all steps in the management of pain are being completed and in compliance with the program.

Grounds / Motifs :

1. The non-compliance was issued as a CO due to a severity level of 2 (minimal harm or potential for actual harm) a scope of 3 (widespread) and a compliance history of 2 (previous non compliance)

The licensee failed to ensure that the pain management program to identify pain in residents and manage pain was developed and implemented in the home.
In accordance with s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices

or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

At the time of the inspection, the pain management program was not developed and implemented in the home.
• The home failed to provide a written description of the program that included the goals and objectives.
• Policies and procedures provided by the home were outdated.
A) The Pain Management Policy Appendix VII indicated that residents on scheduled pain management medications would have a weekly summary completed, which evaluated pain control measures and effectiveness of medication. The Pain management lead reported that this policy was no longer current and that the home completed a monthly pain evaluation summary.
B) Another pain management policy by the same name provided by the home indicated that resident on scheduled pain management medications would have a monthly evaluation summary completed which evaluated pain control measures and effectiveness of pain medications. This summary was not found to be completed for the month of October, 2017 for resident #031. There was no policy on how to complete the monthly evaluation summaries and were found to contain data but not an evaluation of pain management for resident #031.
C) The policies provided indicated that referrals to other disciplines were made as needed, however, did not indicate the protocol to do so.
D) There was no policy in regards to the administration and evaluation of PRN medication.
E) Interview with the pain committee lead on November 22, 2017 reported that they use a "three on three" approach with regards to PRN medication. This approach means that if a resident was administered a PRN medication three times in one day or three days in a row, they would notify the physician. As confirmed with the pain management lead as well as DOC #10.
• The annual program evaluation provided by the home dated April 11, 2017 contradicted what staff had provided to the inspector. The evaluation indicated "yes"

that the home had a formalized pain management program that included written program description, goals and objectives, relevant policies and procedures, protocols and methods to reduce risk, tracking tools that monitor outcomes and protocols for referrals to specialized resources where required which were not provided at the time of the inspection. Interview with the Quality Improvement Coordinator confirmed that the evaluation did not provide those listed above. It was also confirmed that the evaluation did not include a summary of the changes made and the date that those changes were implemented.
• The program did not identify pain management in resident #031. Resident #031 was noted to have 'as needed' (PRN) pain medications administered multiple times over several months in addition to regularly scheduled pain medications; however, the use of the regularly scheduled medications in relation to the use of PRN medications was not evaluated.

An organized program for pain management was not developed and implemented in the home as confirmed with the Administrator, DOC #101 and DOC #103.

(156)

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

Apr 06, 2018

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_587129_0007, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. Duty to protect

Order / Ordre :

(A1)
1. The licensee shall ensure all residents, including resident #042 are protected from abuse by anyone.

2. The licensee is to review and revise the policies and procedures related to the prevention of abuse and neglect to ensure that these documents provided clear direction to staff related to the actions to take when staff suspect a resident may have been abused, staff receive an allegation of abuse or staff witness abuse. The revision to the policies and procedures is to include specific pathways and tools for the implementation of those directions. The review and revision of the licensee's policies and procedures related to the prevention of abuse and neglect of residents is to be completed by February 28, 2018.

3. The licensee is to develop and implement a mechanism to ensure that staff have quick and easy access to directions related to the prevention of abuse and neglect of residents as well as the directions for the assessment and management of responsive behaviors demonstrated by residents, included in the licensee's policies and procedures.

4. The licensee is to provide face to face training for all staff related to the revised policies, procedures, pathways, tools and process for quick and easy access to information related to the prevention of abuse and neglect of residents. All documentation related to the content of training programs provided and attendance at those programs is it to be maintained by the home.

5. The licensee is to develop and implement an auditing process to regularly assess staff's knowledge of the actions to take related to potential abuse situations. The auditing process is also to include a review, by nursing leadership, of all incident reports and clinical notations that indicate a possible abuse situation or any situation that may result in an increased risk for an occurrence of resident abuse. Documentation of the above noted auditing activities is to be maintained in the home.

Grounds / Motifs :

(A1)
1. The non-compliance was issued as a CO due to a severity level of 2 (minimal harm or potential for actual harm), a scope of 1 (isolated) and a compliance history of 4 (ongoing non compliance with a CO under the same section in August, 2017).

The licensee failed to comply with the directions in the compliance order served to the licensee on August 16, 2017. The order directed the licensee to review the home’s policy and procedures related to the prevention of abuse and neglect and where necessary revise these documents to ensure that they provide clear directions to staff related to the actions to take when staff suspect a resident may have been abused, staff receive and allegation of abuse or staff witness abuse. The compliance date for the compliance order issued on August 16, 2017 was October 16, 2017.
At the time of this inspection the Administrator confirmed that no person in the home participated in a review of the licensee’s policy and procedures related to the prevention of abuse and neglect. Director of Care (DOC) #101 confirmed that the licensee’s policy and procedures related to the prevention of abuse and neglect had not been viewed during corporate DOC meetings.
The documents provided by the home and related to the above noted policy and procedures did not identify that these documents had been reviewed. Documents provided by the home and represented as the licensee’s policy and procedures related to the prevention of abuse and neglect of residents included:
a) “Abuse and Neglect Policy” located in the Resident Rights section of the Resident Care and Service Manual, identified as RCS P-10 with an original date of December 19, 2000 and a revised dated of July 2, 2015
b) “Resident Abuse and Neglect Policy” located in the Nursing/Resident Care Annual Evaluation section of the Quality Improvement Program Manual, identified as QIP I-05-50 with a revised date of March 10, 2017.
c) “Resident/Resident Assaults”, located in the Resident Safety section of the Resident Care and Services Manual, with an original date of March 23, 2001 and a revised date of March 31, 2017.

The home provided a document identified as a final draft of the “Corrective Action Plan” for Order #001 related to the previous compliance order for Long Term Care Home 2017 c. 8, s.19(1). This document identified the action steps to be taken to achieve compliance. The document did not contain an action step to review the licensee’s policy and procedures related to the prevention of abuse and neglect.
At the time of this inspection staff in the home were unable to provide any documentation to confirm that a review of the licensee’s policy and procedures

related to the prevention of abuse and neglect had been reviewed as was directed in the compliance order.

3. The licensee failed to protect resident #042 from physical abuse by co-resident #041.
In accordance with Ontario Regulation 79/10, s. 2 (1) physical abuse is defined as "the use of physical force by a resident that causes injury to another resident".
Resident #042, DOC #101 and clinical documentation confirmed that on an identified date in November, 2017, resident #042 was physically abused by co-resident #041. As a result of the actions of the co-resident, resident #042 sustained an injury. Resident #041 was able to recall the incident at the time of this inspection. Clinical documentation confirmed that the day following the incident registered staff became concerned and the resident was transferred to hospital. The resident returned to the home. The clinical record indicated that resident #041 had demonstrated physically aggressive behaviour towards co-residents on identified dates in April and March 21, 2017, November and August, 2016 prior to the incident noted above in November, 2017.
(129) (129)

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

Apr 06, 2018

Order # /
Ordre no : 003

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

Linked to Existing Order /
Lien vers ordre existant: 2017_587129_0007, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Order / Ordre :

1. The licensee will review and revise where necessary the policy and procedure related to responsive behaviours.
2. The licensee is to implement the policy and procedure and to develop a process for staff to use to identify possible triggers for responsive behaviours being demonstrated by residents.
3. The licensee is to provide training to all registered staff on the implementation of the policy and procedure and the process for staff to use to identify possible triggers for responsive behaviours being demonstrated by residents.
4. The licensee is to provide training to all non-regulated staff that provide care to residents on the implementation of the process for staff to use to identify possible triggers for responsive behaviours being demonstrated by residents.
5. The licensee will create an audit to ensure that all steps in the responsive behaviour process for staff to use to identify possible triggers for responsive behaviours being demonstrated by residents.

Grounds / Motifs :

1. The non-compliance was issued as a CO due to a severity level of 2 (minimal

harm or potential for actual harm), a scope of 2 (pattern) and a compliance history of 4 (ongoing non compliance with a CO under the same section in August, 2017).

The licensee failed to ensure that written approaches to care as well as resident monitoring an internal reporting protocols were developed to meet the needs of the residents with responsive behaviours.

The licensee failed to comply with the following activities that the home was ordered to complete as part of the compliance order for O. Reg. 79/10, s. 53 (1) served on August 16, 2017. The compliance order was to be complied by October 16, 2017.

1. The licensee was to develop and implement a policy, procedure and tool to be used when attempting to identify possible triggers for responsive behaviours being demonstrated by residents. An interview with the Staff Educator on November 21, 2017, confirmed that tool was being piloted in the home and the final version of the responsive behaviour debrief tool was not given to the home until the end of October, 2017. In an interview with DOC #101 on November 17, 2017, confirmed that the home did not have a policy or procedure for the responsive behaviour debrief tool and that the staff had not been trained on this tool. The home produced a procedure for the responsive behaviour debrief tool on November 20, 2017 and confirmed that this is the first time the home was given the procedure for how to use the responsive behaviour debrief tool.

2. The licensee was to provide face to face training for all staff related to the implementation of the above noted tool. The home is to maintain specific subject matter an attendance records for this training. An interview with the staff Educator and DOC #103 confirmed on November 21, 2017, that only three registered staff out of fifty-five had been trained on the use of the tool because the home did not have the final version of the tool available as well as a policy and procedure in place to educate and implement the tool.

3. The licensee was to implement the above noted tool and reassess all residents who demonstrate responsive behaviours for possible triggers for each responsive behaviour demonstrated. Plans of Care are to be developed, implemented and evaluated related to the management of identified behavioural triggers. An interview with the MDS RAI co-ordinator on November 21, 2017, confirmed that the above noted tool was not implemented and residents who demonstrate responsive behaviours were reassessed.

4. Clinical records reviewed for resident #034 and resident #035 confirmed that these residents were identified to demonstrate responsive behaviours and there was no clinical documentation to indicate that an attempt to identify triggers for the specific behaviours being demonstrated by these residents were completed. DOC #101 confirmed that the home did complete the responsive behaviour debrief tool but did not identify the trigger for the responsive behaviour and there were no written approaches for staff to follow.
(506)

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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 7 day of February 2018 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : CAROL POLCZ - (A1)

Service Area Office / Bureau régional de services : Hamilton