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**

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**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 |
|---|---|---|---|
| Jun 7, 2018 | 2018_716554_0004 | 004529-18 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

The Corporation of the City of Kawartha Lakes
26 Francis Streeet P.O. Box 9000 LINDSAY ON K9V 5R8

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

Victoria Manor Home for the Aged
220 Angeline Street South LINDSAY ON K9V 4R2

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

KELLY BURNS (554), LYNDA BROWN (111)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): March 05-09, 12-16, and March 19-22, 2018**

**Resident Quality Inspection Intake #004529-18. Intakes #009992-17, #010153-17, #010310-17, #011709-17, #017706-17, #016069-17, #017137-17, #018392-17, #018544-17, #018718-17,#021470-17, #022147-17, #025331-17, #020908-18, #000762-18, #001339-18, #02030-18, and #003772-18**

**Summary of Intakes:**

**#009992-17, #0101310-17, #017137-17, #018392-17, #018544-17, #018718-17, #020908-18, ,#021470-17, and #003772-18 – Critical Incident Report (CIR) – alleged resident to resident abuse;**
**#010153-17 – Complaint – related to resident care;**
**#016069-17, #025331-17, and #001339-18 – Critical Incident Report – for an incident which resulted in injury for which the resident was transferred to hospital and resulted in a significant change in residents condition;**
**#011709-17, #017706-17, and #022147-17, and #000762-18 – Critical Incident Report – related to medication management specifically controlled substances;**
**#02030-18 – Complaint – related to 24 hour nursing care.**

**During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Associate Director of Care, Office Manager, Building Services Manager, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Behaviour Support Team, Building Services Aid(s), Dietary Aid(s), Physiotherapist, President of Resident Council, Family, and residents.**

**During the course of the inspection, the inspector(s) toured the long-term care home, observed staff to resident interactions, observed resident to resident interactions, observed meal and snack service, reviewed clinical health records, licensee specific investigations, Resident Council meeting minutes, Complaints Records, Medication Incidents for an identified period, Quality Management Evaluation Tools, specifically for Infection Prevention and Control (IPAC), Staffing Contingency Plan, registered nursing schedules and time sheets; reviewed IPAC training for identified staff; and reviewed licensee policies specific to, Complaints Management Program, Equipment Cleaning-Resident Care and Medical Equipment, Clothing Care and Personal Effects, Personal Protective Equipment, Routine Precautions, Contact Precautions, Prevention of Abuse and Neglect of a Resident, Hygiene, Personal Care, and Grooming, Skin and Wound Care Management Protocol, Responsive Behaviours, Medication Management Systems and Medication Incidents.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Continence Care and Bowel Management**
**Falls Prevention**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**
- **15 WN(s)**
- **15 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (2) The licensee shall ensure that the care set out in the plan of care is based**

**on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).**

**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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).**

**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).**

**s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,**
**(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).**
**(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).**

**Findings/Faits saillants :**

The licensee failed to ensure there was a written plan of care for resident #003 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 related to use of a identified safety device.

On an identified date, resident #003 was observed by Inspector #111 with a safety device on, the safety device was loosely applied. The resident was unable to remove the safety

device when requested to.

Interview with PSW #126 by Inspector #111, indicated resident #003 used the safety device when in an identified mobility aid for safety as the resident would lean forward. PSW indicated that the safety device was considered a restraint. The PSW indicated the safety device should be documented in the electronic health record, and that documented was to occur hourly, identifying application, repositioning and removal of the safety device.

Interview with RPN #128 by Inspector #111, indicated resident #003 used the identified safety device when up in the mobility aid, but had no awareness whether the safety device used was a restraint or a PASD.

Interview with Substitute Decision Maker (SDM) of resident #003 by Inspector #111, indicated the safety device was used for comfort only when resident was up in the mobility aid and indicated that the resident was able to remove/reapply.

Review for the health care record for resident #003 had no documented evidence related to the use of the safety device when in the mobility aid.

The licensee failed to ensure there was a written plan of care for resident #003 that set out, the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident related to use of a safety device. [s. 6. (1)]

2. The licensee failed to ensure the resident was provided care according to the resident's needs and preferences.

Related to Intake #025331-17:

A Critical Incident Report (CIR) was submitted to the Director on an identified date for an injury for which the resident was taken to hospital and resulted in a significant change in condition. The CIR indicated that ten days earlier, staff heard resident #011 yelling, and found resident caught in another resident's mobility aid.

Review of the health care record for resident #011 indicated the resident required staff assistance with mobility and used an identified mobility aid that was to be tilted when up.

Progress notes indicated the resident #011 had incidents on during two separate occasions and sustained injuries.

- On an identified date, RPN #134 heard the resident yelling in the main lounge and found the resident was caught in another resident's mobility aid. RPN assessed resident to have no injury. Approximately six hour later resident #011 expressed having discomfort and was administered an analgesic; progress notes did not document that resident #011 was assessed. The next morning, approximately twelve hours later, a PSW reported that resident #011 was expressing discomfort, resident was administered an analgesic. Approximately five hours later, RPN reported to RN #120 that resident #011 had been involved in an incident, involving another resident's mobility aid, and was now expressing discomfort, had been administered analgesics, and was now assessed to have bruising and swelling to an identified area. RPN indicated to RN that a note had been left in the doctor's book, to assess resident. Resident #011 continued to complain of discomfort and was administered an analgesic. Thirty-six hours after the initial incident, RPN #134 indicated to an RN that resident #011 continued to complain of discomfort, an analgesic had been administered and that resident had bruising and swelling to an identified area. RN #135 assessed resident. RN notified the Substitute Decision Maker (SDM) of incident, "explained treatment options" and SDM agreed to have resident assessed by Nurse Practitioner (NP) the following day. Resident was assessed by the NP the next day, new orders were received for diagnostic testing. SDM was notified of the NP's orders.

- On an identified date, three days after the first incident, resident #011 sustained a fall, and was assessed to have no injuries. Resident #011 continued to complain of discomfort as a result of the initial injury (three days earlier).

- The day following the NP's orders, resident #011 had diagnostic testing completed, in house. Results of the diagnostic test was received later that day, and communicated to NP. The results were communicated to resident #011's SDM. SDM agreed to have resident seen in a community clinic; no date of this appointment is documented. The next day NP contacted the community clinic to arrange for an appointment, an appointment could not be arranged for another six days, the decision was made to transfer resident #011 to hospital for assessment.

- On an identified date, approximately two months later, the resident #011 had a fall, was assessed to have no injury. Resident #011 did complain of discomfort and was administered an analgesic. SDM was notified of the incident. Approximately twelve hours

later, resident #011 was assessed to have bruising to two identified areas. Three hours later resident complained of discomfort and was administered an analgesic, the analgesic was re-administered four hours later. Resident continued to complain of discomfort; diagnostic was ordered. Two days following the incident, the diagnostic test was completed, and results communicated to the physician and/or NP.

Inspector #111 interviewed RPN #134 as to the process surrounding assessment of resident discomfort, and actions taken. RPN #134 indicated recall of the initial incident, and indicated that the incident was not communicated to the RN until the next day, nor was the incident documented.

Inspector #111 interviewed RN #120. RN indicated not being aware of the incident until the day following the incident, by RPN #134. RN #120 indicated that resident #011 was assessed, but the assessment was not document for five days. RN #120 indicated that the assessment had been communicated to the oncoming shift, RN and RPN, to contact the SDM. RN #120 indicated the incident was not communicated to the On Call Manager and or had the incident been documented in Risk Management (electronic incident report).

Inspector #111 interviewed RPN #137. RPN indicated being aware of the discomfort resident was experiencing, and had administered analgesics. RPN indicated that the SDM had not been contacted, nor was the RN made aware of the incident.

The licensee has failed to ensure that resident #011 was provided care according to the resident's needs and preferences. [s. 6. (2)]

3. The licensee failed to ensure the resident, the SDM, if any, and the designate of the resident /SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

Related to Intake #025331-17:

A Critical Incident Report (CIR) was submitted to the Director on an identified date for an injury for which the resident was taken to hospital and resulted in a significant change in condition. The CIR indicated that ten days earlier, staff heard resident #011 yelling, and found resident caught in another resident's mobility aid.

Review of the health care record for resident #011 indicated the resident sustained an

injury on two separate occasions and the SDM was not informed for approximately two days, on the following each incident.

Inspector #111 interviewed RPN #134 who had worked the date of the initial incident. RPN #134 indicated that the incident was no communicated to the SDM.

Inspector #111 interviewed RPN #137 who worked the evening shift, following the incident. RPN indicated being told of the incident, and indicated that the incident was not communicated to the SDM, nor was the RN notified.

SDM for resident #011 was notified of the incident, two days following.

The licensee has failed to ensure resident #005's SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

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

Related to Intake #025331-17:

Review of the health care record for resident #011 indicated that resident #011 required an identified mobility aid, which was used as a PASD to support resident's activities of daily living. The resident required one staff's assistance to transfer to all areas of the home. The current written plan of care indicated the resident was a high risk for falls. Interventions included: keep mobility aid tilted backwards at all times (excluding meals); use of an alarm device while in bed/in mobility aid and staff to ensure alarm device is attached and in working order.

Review of the progress notes for resident #011 indicated:

- On an identified date, resident #011 was found on the floor in a lounge in front of their mobility aid, after the alarm device sounded. Resident slid out of the mobility aid. PT assessed the resident post incident, indicated the resident slid from mobility aid. RN #107 reported resident's mobility aid was not in the tilt position when the resident slid out of the mobility aid. The PT also discussed use of an anti-slide for the mobility aid as resident will often slide while in the identified mobility aid.

- Sixteen day later, RPN #134 indicated the resident was calling out for help, and was found caught in another resident's mobility aid. Resident #011 sustained injury as a result of this incident.

- Two day later, RPN #134 indicated the resident's mobility aide was malfunctioning and contacted the service provider for repair.

- The next day, resident #011 was found on the floor in their room, beside the bed. The alarm device was attached to the resident but not ringing. PT assessed the resident post incident and indicated the tilting mechanism for the mobility aid and the head rest were broken and the mobility aid was sent for repair. The mobility aid was repaired and returned the same day.

- Approximately two months later, on an identified date resident #011 was found on the floor in a lounge in front of the mobility aid. The alarm device was not in place. The resident #011 complained of discomfort following the incident.

Interview with RPN #134 by Inspector #111. RPN #134 indicated that resident #011's mobility aid was to be in the tilt position at all times, except at meal times. RPN #134 indicated awareness that the mobility aid was malfunctioning. RPN #134 indicated the service provider was contacted for repair of the mobility aid.

Review of the of the health record, and interview with staff indicated that care set out in the plan of care was not provided to resident #011 specific to the tilt of the mobility aid, and the alarm device not being in place or functioning during identified dates.

The licensee has failed to ensure that the care set out in the plan of care, was provided to resident #011 as specified in the plan related to falls prevention and management. [s. 6. (7)]

5. The licensee has failed to ensure that staff and others who provide direct care to a resident were aware of the contents of the plan of care and have convenient and immediate access to it.

Related to Intake #016069-17:

A Critical Incident Report (CIR) was submitted to the Director for a fall with injury for which the resident was transferred to hospital and had a significant change in condition.

The CIR indicated on an identified date, resident #023 was found lying on the floor. The resident #023 sustained injury. Resident #023 continued to experience discomfort the next day, was assessed to have an identified injury and was later transferred to hospital.

Review of the health care record indicated that resident #023 was admitted in 2017, and had fallen on an identified number of occasions since admission. Resident was assessed as being at risk for falls.

Review of the current written plan of care for resident #023 indicated the resident was a high risk for falls. Interventions included an identified restraint while up in a mobility aid; call bell within reach; wear proper and non-slip footwear, ensure alarm/sensor pad is on and in position while in bed and in mobility aid; place bed in lowest position and fall mat to be placed on door side of bed.

Interview with RPN #106 by Inspector #111, indicated that RPN #105 was not familiar with the unit, where resident #023 resided.The RPN indicated no awareness of level of fall risk for resident #023.

Interview with PSW #125 by Inspector #111, indicated that PSW #125 was not being familiar with resident #023, but that they did work on the unit where resident resided. The PSW indicated no awareness of level of fall risk for the resident. PSW #125 indicated the only falls intervention that they were aware of for the resident #011, was that resident was to have shoes when up and that resident was to have an alarming device in place as an intervention to prevent falls.

The licensee has failed to ensure that staff who provided direct care to resident #023 were aware of the contents of the resident's plan of care related to falls prevention and management. [s. 6. (8)]

6. The licensee has failed to ensure that when the plan of care was being reviewed and the resident was being reassessed, when the resident's care needs changed, the plan of care was revised related to falls risk.

Related to Intake #016069-17:

A Critical Incident Report (CIR) was submitted to the Director for a fall with injury for which the resident was transferred to hospital and had a significant change in condition. The CIR indicated that on an identified date, resident #023 was found lying on the floor.

The resident was assessed to have a specific injury. The next day, staff noted resident #023 to be in discomfort, resident was assessed to have further injury related to the fall. The resident was transferred to hospital for further assessment.

Review of the progress notes for resident #023 indicated the resident sustained a number of falls since admission to the long-term care home. A review of the care plan indicated that the following interventions were in place: two staff with a mechanical lift for all transfers; identified mobility aid with staff's assistance; identified restraint while in mobility aid; ensure alarm/sensor pad is on and in position when in bed and in mobility aid.

Interview with RPN #125, who is the Falls Prevention Lead, by Inspector #111, indicated the falls prevention team usually meets weekly to discuss residents at high risk for falls. The RPN indicated resident #023's fall had not been discussed since an identified date at (falls) meetings. The RPN #125 was not aware the resident was at high risk for falls, had sustained a number of falls. RPN indicated that there was no documentation of interventions being discussed and or revised related to resident #023 at any of the falls prevention meetings.

A review of post-fall huddle reports for resident #023 indicated that there were reports for half of the falls for this resident. Interventions discussed during the huddles were, need for a toileting program, encourage use of an identified mobility aid and medication review was suggested. The written plan of care was not revised to include these interventions. After an identified fall, a clip alarm device was introduced as an intervention. After another identified fall, every 15 minute checks was introduced as an intervention. There is no documentation that the plan of care was revised following two identified falls.

The licensee has failed to ensure that when the plan of care, for the resident was reviewed and the resident was reassessed that the plan of care was revised related to falls prevention and management, specific to resident #023. [s. 6. (10) (b)]

7. The licensee failed to ensure that when the resident was reassessed and the plan of care was reviewed and revised because the care set out in the plan has not been effective, that different approaches were considered in the revision of the plan related to risk for falls.

Related to Intake #001339-18:

A Critical Incident Report (CIR) was submitted to the Director, on an identified date, for a fall resulting in injury for which the resident was transferred to hospital and resulting in a significant change in condition. The CIR indicated two days earlier, resident #022 was found lying on the floor. Resident indicated being in discomfort, and was assessed to have had sustained injury. Resident was transferred to hospital for further assessment. CIR indicated resident had a history of falls.

Review of the health care record for resident #022 indicated the resident was admitted in 2017. Substitute Decision Maker indicated that resident had an identified number of falls in an identified time period prior to the admission.

Admission nursing staff indicated that resident #022 may need an alarm device on their bed.

Further review of the written plan of care for resident #022 indicated the resident was at high risk for falls. Interventions in place included place adaptive aid in field of vision so resident does not have to pivot; reinforce need to call for assistance; call bell within reach when in bed; wear proper and non- slip footwear; and encourage use of handrails or assistive devices properly.

Following resident's admission, resident sustained a number of falls, on identified dates, an identified number of falls resulted in injury.

RPN #125, who was the Falls Program Lead, was interviewed by Inspector #111. RPN #125 indicate the Falls Prevention Committee meets weekly, RPN indicated the committee looks at falls occurring and discusses possible interventions for residents. RPN #125 indicated new interventions are documented in the plan of care for the individual resident.

The Falls Prevention Committee meeting minutes were reviewed, by Inspector #111, for the 2017 and 2018 (to date). Falls sustained by resident #022 was discussed once, following a specified number of falls.

The plan of care for resident #022 failed to identify documented evidence that intervention had been discussed or had been reviewed and or revised specific to falls prevention and management for resident #022. The alarm device which was discussed on admission had not been implemented until after an identified number of falls.

The licensee has failed to ensure that when the resident was reassessed and the plan of care was reviewed and revised because the care set out in the plan has not been effective, that different approaches were considered in the revision of the plan related falls prevention and management for resident #022. [s. 6. (11) (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 there is a process in place and monitored, ensuring there is a written plan of care for residents 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; that residents are provided care according to the resident's needs and preferences; that the resident, the SDM, if any, and the designate of the resident / SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care; that the care set out in the plan of care, was provided to the resident as specified in the plan related to falls risk; that staff and others who provide direct care to a resident kept aware of the contents of the plan of care and have convenient and immediate access to it; hat when the plan of care was being reviewed and the resident was being reassessed, when the resident's care needs changed, the plan of care was revised related to falls risk; and that when the resident is reassessed and the plan of care is reviewed and revised because the care set out in the plan has not been effective, that different approaches were considered in the revision of the plan related to risk for falls, to be implemented voluntarily.***

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Under O. Reg. 79/10, s. 114 (2) - The licensee is to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee's policy, 'Controlled Substances and Narcotic Counts' indicated:
- The DOC will ensure that a monthly audit of the daily count sheets for narcotic and controlled substances is conducted to determine if there are any discrepancies and that immediate action is taken when discrepancies are discovered.
- The RN/RPNs will: conduct a controlled and narcotic shift count in the RHA (resident home area) at each shift change; verify counts of quantities noted as a balance on each residents individual count sheet and shift count sheet if used. This will reflect the number of controlled substances/narcotics present in the home at the beginning of each shift. When conducting a drug count: view the container of the drug, verify the count in the container against the residents individual drug/narcotic count sheet; ensure accuracy of the count by having one verbally state the residents name, the name and strength of the drug, and the number of each controlled substances/narcotics counted to the second nurse, who will record the number on the drug/narcotic shift count sheet.

The licensee policy, 'Individual Monitored Medication Record' indicated under procedures:
- Document for the administration of the monitored medication on the residents MAR
- Sign on the individual monitored medication record each time a dose is administered.

Include the date, time, amount given, amount wasted and new quantity remaining.

The licensee policy 'High Alert Medications' indicated:
- Double checks or independent double checks are required for an identified controlled substance. An independent double check is recommended to lower the risk of medication incidents. The process included two registered staff independently complete a check of the narcotic and then compare for discrepancies.

Related to Intake #000762-18:

A Critical Incident Report (CIR) was submitted to the Director on an identified date for a missing controlled substance. The CIR indicated on two days earlier, Registered Practical Nurse (RPN) #110 was preparing to administer an identified medication for resident #026. The RPN removed the plastic sleeve of vials from the package and discovered that a few of the vials of the identified medication were empty. The RPN contacted Registered Nurse (RN) #111 to report the missing medication. The Associate Director of Care completed the CIR.

Review of the licensee's investigation, review of the health record of resident #026 indicated resident #026 was prescribed an identified medication which was to be given routinely and as needed (PRN).

On an identified date, RPN #110 completed shift count with RN #113. Neither of the registered staff removed the plastic sleeve from the package to confirm actual quantity, of the controlled substance, was the same as the amount recorded on the individual Monitored Medication Record as per the licensee's policy. RPN #110 had also prepared for the administration of the controlled substance without a double check as per the licensee's policy. The licensee's investigation also revealed RPN #112, RN #113, RN #115 were also not removing the plastic sleeve of vials from the packaging for the controlled substance when completing the shift count (confirming actual quantity) and were not having a double check completed at time of administration of controlled substance. In addition, the investigation revealed RN #113 left the medication/narcotic keys unattended and that RN #115 had access to the medication room during that time period.

RPN #109 indicated, to Inspector #111, that previously the practice with shift count of controlled substances consisted of the registered staff just checking the vials through the open window of the packaging but since the incident, the practice has been revised. The

RPN indicated the process for the double check of controlled substances has also been revised.

RPN #101 indicated, to Inspector #111 that the current practice is at the end/beginning of shift, registered staff are to remove any controlled substances vials from the package when completing narcotic shift count. The RPN indicated that registered nursing staff should never leave their medication cart keys unattended.

The ADOC indicated, to Inspector #111, that the licensee's investigation confirmed that registered nursing staff were not removing the plastic sleeve of controlled substances from the box while completing the shift count to ensure accurate count of vials. The ADOC indicated all registered nursing staff were immediately notified of change in procedure related to safe storage of medication keys, double checks with administration of controlled substances, and proper shift counts.

The Director of Care (DOC) confirmed with Inspector #111, that the home did not complete a monthly audit of the controlled substances.

The licensee failed to ensure that identified Medication Management Systems policies, of the licensee, were complied with as Registered Nursing staff were not completing actual counts of controlled substances at the beginning and end of shift counts, were not completing the independent double checks when preparing and administering controlled substances and that monthly audits were not being completed.

2. Related to Intake #011709-17:

A Critical Incident Report (CIR) was submitted to the Director on an identified date for an unaccounted for controlled substance. The CIR indicated that a day earlier, RPN #112 and RPN #150 discovered an identified medication was missing for resident #052 and reported the incident to RN #151. The CIR indicated the home was unable to locate the missing medication. The CIR was completed by the ADOC.

Review of the health record for resident #052 and the licensee's investigation indicated:
- The resident was prescribed an identified medication twice daily as needed.
- The individual monitored medication record (IMMR) indicated the resident received the identified medication on specific dates and during identified times. The electronic Medication Administration Record (eMAR) identified dates and times that resident #052 received the identified medication. Documented records indicated inconsistencies on five

separate dates.

The licensee has failed to ensure the identified Medication Management Systems policies of the licensee, were complied with as Registered Nursing staff were not ensuring that when an identified medication was administered, that it was recorded consistently on eMAR and the IMMR to ensure consistency and accuracy in the amounts received.

3. Related to Intake # 017706-17:

A Critical Incident Report (CIR) was submitted to the Director on an identified date for a missing controlled substance. The CIR indicated that four days earlier, RPN #112 and RPN #145 were completing end of shift count and discovered an identified controlled substance was missing for resident #053. The CIR indicated the incident was reported to RN #107. The CIR indicated the controlled substance was not located. The CIR was completed by the ADOC.

Review of the health record for resident #053 and the licensee's investigation indicated:
- The resident was prescribed the identified controlled substance at specific times,
- A review of the IMMR indicated that on two identified dates, registered nursing staff were not consistently identifying dates, times and or who administered an identified controlled substance. It was further determined that the quantity of the identified controlled substance remaining following administration was inconsistently documented on both the IMMR and shift count sheets, by registered nursing staff.

The licensee failed to ensure that identified Medication Management System policies were not complied with as Registered Nursing staff as indicated above.

4. Related to Intake #022147-17:

A Critical Incident Report (CIR) was submitted to the Director on an identified date for an unaccounted for controlled substance. The CIR indicated that a day earlier, RPN #112 discovered an identified controlled substance was missing for resident #025. The CIR indicated the home was unable to locate the missing controlled substance and the police were notified. The CIR was completed by the ADOC.

Review of the health record for resident #025 and the licensee's investigation indicated:
- The resident was prescribed an identified controlled substance.

- The review of the IMMR indicated on an identified date, the resident was given the prescribed controlled substance with identified number remaining. On same date, the resident was administered the controlled substance again, the nurse documented that count was incorrect.
- A review of the shift count indicated on an identified date, the count of an identified controlled substance remaining. Eight hours later, the count was altered initially indicating that a number had been written over the initial count. Eight hours following that, the count indicated, initially that a number were remaining, and that the initial count was again altered.

Interview with both the DOC and the ADOC by Inspector #11 indicated the expectation was that the IMMR should correspond with the eMAR and the shift counts should be completed according to the policy.

The licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with specific to medication management. [s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, specifically as such relates to Medication Management Systems, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that there was at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement.

In this section "regular nursing staff" means a member of the registered nursing staff who works in a long-term care home at fixed or prearranged intervals.

Under O. Reg. 79/10, s. 45 (1) – exceptions to the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, as required under subsection 8 (3) of the Act. Note: The exceptions in this regulation are specific to: 1. Homes with a licensed bed capacity of 64 beds or fewer; 2. Homes with a licensed bed capacity of more than 64 beds but fewer than 129 beds.

Related to Intake #002030-18:

Victoria Manor Home for the Aged has a licensed bed capacity of 166 beds, including two short stay beds. Victoria Manor does not qualify for the exceptions to the requirement under O. Reg. 79/10, s. 45 (1).

The DOC indicated, to Inspector #554, that there is at minimum one RN on duty and present in the long-term care home at all times. The DOC indicated being unaware of any dates in 2017 and/or during the first-quarter of 2018 where there was no RN on duty or present in the home.

The 'Two Week Schedule Report', as well as the 'RN Six Week Schedule' were reviewed, by Inspector #554, for an identified six month time period.

Staff #200 indicated, Inspector #554, that the two documents, identified above, identify which RN was scheduled and worked during the identified six month period. This was confirmed by the Office Manager and the DOC.

Documents reviewed identified that there was no RN on duty and present in the long-term care home, during the night shift, on an identified date.

Staff #200 indicated that an RN who was scheduled to work, on the night shift on the

identified date, had been sent home for reasons known to the on call manager. Staff #200 indicated that there was no indicated replacement on the schedule.

The Office Manager confirmed that there was no RN on duty and present in the home on an identified date, during the night shift.

The DOC indicated being unaware that there was no RN on duty and present in the home during the night shift on the identified date. Following further discussion, the Director of Care indicated being aware that the RN who was scheduled to work nights on the identified date, had left the home at 2200 hours for reasons known to the on call manager. The DOC provided confirmation that there was no RN on duty and present in the home on an identified date.

The licensee failed to ensure that there was at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present in the long-term care home during the night shift on an identified date. [s. 8. (3)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored to ensure there was at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times, to be implemented voluntarily.***

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

The licensee has failed to ensure the person who had reasonable grounds to suspect that, abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Related to Intake #003772-18:

A Critical Incident Report (CIR) was submitted to the Director, on an identified date, for a witnessed resident to resident abuse incident.The CIR indicated that a PSW reported to an RPN, that resident #047 was witnessed exhibiting an identified behaviour towards resident #049. Resident #049 indicated being hurt and scared. The CIR indicated RPN immediately reported the incident of abuse to RN #135. The abuse incident was reported to the Director the day after the occurrence, using the after-hours reporting system.

The ADOC indicated, to Inspector #111, that the Director was notified the day following the incident, when it was discovered that the registered staff had not contacted the Ministry of Health.

The licensee has failed to ensure the person who had reasonable grounds to suspect that, abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, had occurred or may occur, immediately reported the

suspicion and the information upon which it was based to the Director, specifically, abuse of a resident #049. [s. 24. (1)]

2. The licensee has failed to ensure that abuse of a resident by anyone is immediately reported to the Director.

Related to Intake #021470-17:

The Director of Care submitted a Critical Incident Report (CIR) to the Director on an identified date. The CIR was related to an alleged incident of resident to resident abuse involving residents #029 and #030. Resident #030 indicated that resident #029 exhibited an identified responsive behaviour towards them. Resident #029 was assessed by registered nursing staff to have sustained injury. The alleged abuse occurred two days earlier. As indicated in the CIR, resident #030 reported the allegation to PSW, who reported allegation to RPN #152, who intern reported the allegation to RN #151, who was the assigned Charge Nurse.

RPN #152 indicated, to Inspector #554, that the alleged abuse was reported to Charge Nurse-RN #151, on the date of the occurrence. RPN #152 indicated that all alleged, suspected and witnessed abuse is reportable to the RN-Charge Nurse, Supervisor and or management.

RN #151 was unavailable for an interview during this inspection.

The Director of Care indicated, to Inspector #554, that management first became aware of this incident while reading report, two days following the incident. The Director of Care indicated that the Charge Nurse's responsibility includes notification of the Ministry of Health and Long-Term Care (MOHLTC) of any alleged, suspected or witnessed abuse, indicating further that the Charge Nurse is to access MOHLTC using the after-hours contact number. The Director of Care indicated that all staff have been provided training on reporting of abuse.

The licensee failed to ensure that alleged resident to resident abuse which occurred on an identified date, and involved residents #029 and #030, was not immediately reported to the Director. [s. 24. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director, specifically as such relates to abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**

**Specifically failed to comply with the following:**

**s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

**Findings/Faits saillants :**

The licensee failed to ensure that resident #028 was bathed, at a minimum, twice a week by a method of resident's choice, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Related to Intake #010153-17:

Substitute Decision Maker (SDM) for resident #028 indicated, to Inspector #554, that resident #028 was not provided twice weekly bathing, especially during an identified month in 2017.

PSW #104, and #154 indicated, to Inspector #554, that resident #028 was dependent on staff for care. PSW's indicated that the expectation is that residents are provided twice weekly bathing. PSW #104 indicated that when a resident refuses bathing, it is reported to the registered nursing staff, by the PSW. PSW #104 indicated that the assigned PSW would document the refusal in the care record, and registered nursing staff would

document resident's bathing refusals in the progress notes.

The clinical health record, for resident #028, was reviewed for a period an identified three month period in 2017. The review identified the following:

The written plan of care:

- Bathing – requires assistance. Interventions include, two staff to provide physical assistance for transfers during bathing, and one staff to assist with bathing; preference is tub baths; document and report to registered nursing staff when resident declines primary bathing preference.

Point of Care (POC) which is an electronic care record, and part of the clinical health record for resident #028 identified:

- Resident #028 was not provided twice weekly bathing, specifically was not bathed on three identified dates during this review period. There is no documentation to support that resident was provided bathing on an alternate date, nor is there documentation on the identified dates indicating resident #028 refused bathing.

The 'Follow Up Question Report', reviewed during this same three month period in 2017 provided confirmation that resident was not provided bathing on the three identified dates.

The Associate Director of Care indicated, to Inspector #554, that according to documentation reviewed resident #028 was not provided bathing on the three identified dates, nor was there documentation to support that resident #028 was provided alternate dates for bathing.

The licensee failed to ensure that resident #028 was bathed, at a minimum, twice a week. [s. 33. (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 there is a process in place and monitored, to ensure that residents are bathed, at a minimum, of twice a week by a method of resident's choice, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care**

**Specifically failed to comply with the following:**

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

**s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).**

**Findings/Faits saillants :**

The licensee failed to ensure that resident #034 received preventative and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Resident #034 indicated, to Inspector #554, that foot care is not being routinely provided during scheduled bath times. Resident #034 indicated foot care was last provided within an identified period of time and indicated that prior to that, foot care was offered and completed on an identified date, by the Associate Director of Care.

The clinical health record, for resident #034, was reviewed and indicated the following:

Written care plan (for an identified date) indicated:
Bathing – requires assistance related to physical limitations. Interventions include,

bathing provided on identified days during the week; two staff present at all times when care is provided; two staff to provide physical assistance throughout bathing, trim nails. (identified revision date)

Progress Notes indicated, that resident #034 was provided foot care, by the ADOC, once during the dates of February and August 2017. ADOC indicated in his/here written note that foot care for resident #034 was to be performed by registered nursing staff weekly.

Point of Care (POC), the electronic care records, specific to bathing and associated foot care, indicated:
Resident #034 received bathing twice weekly in February and March 2018. Care records document that foot care was not provided by nursing staff.

There is no documentation, in the clinical health record, to support that resident #034 refused foot care during the above identified six month review period.

PSW's #104, #105, #108, and #131 indicated, to Inspector #554 that PSWs do not provide foot care to resident #034. All PSW's interviewed, indicated that registered nursing staff, but specifically the Associate Director of Care provides foot care to resident #034.

RPN #101 indicated, to Inspector #554, that any foot care to be provided to residents would be identified in the electronic medication administration record (eMAR). RPN #101 indicated that resident #034 was no identified as needing foot care by registered nursing staff. RPN indicated unit registered nursing staff do not provide foot care to resident #034, that foot care is completed by the ADOC for this resident.

The Associate Director of Care indicated, to Inspector #554, that registered nursing staff are responsible to provide foot care to resident #034 weekly at minimum following bathing.

The licensee failed to ensure that resident #034 received preventative and basic foot care services. [s. 35. (1)]

2. The licensee failed to ensure that resident #034 received fingernail care, including the cutting of fingernails.

Resident #034 indicated, to Inspector #554, that fingernail care is not being routinely

provided daily and or during scheduled bathing. Resident indicated that a bath was provided on an identified date just prior to this interview, and that their nails were not cleaned or cut. Resident #034 indicated that their nails are digging into their skin.

Observations of resident #034's fingernails, by Inspector #554 on identified date, identified that resident's nails were long, jagged and were laden with dark debris. Observations of resident #034's fingernails, by Inspector #554 on dates following the initial observation identified that resident's fingernails remained unchanged.

The clinical health record, for resident #034, was reviewed for a two month period.

Written care plan (current at time of inspection) indicated:
- Hygiene - requires assistance related to physical limitations. Interventions include, one staff to assist with care, including hands. Caution is to be used when washing hands, especially the one identified due to contracture. (identified revision date)
- Bathing – requires assistance related to physical limitations. Interventions include, bathing provided on identified dates; two staff present at all times when care is provided; two staff to provide physical assistance throughout bathing, trim nails. (identified revision date)

Point of Care (POC), the electronic care records, specific to bathing and associated fingernail care, indicated:
Resident #034 received bathing twice weekly during an identified two month period of time. Care records document that fingernail care was not provided by nursing staff.

There is no documentation, in the clinical health record, to support that resident #034 refused fingernail care during the above identified review period.

PSW's #104, #105, #108, and #131 indicated, to Inspector #554, that PSW's provide fingernail care to all residents on their assigned bath days, and as required. PSW's #104, and #108 indicated that they do not wash resident #034's hands with morning care, and would not notice if resident's fingernails were dirty or not. Both PSW #104 and #108 indicated that resident #034 washes own hands.

RPN #101 indicated, to Inspector #554, that any fingernail care is to be provided to residents on their assigned bath days, and or as needed. RPN #101 indicated if a PSW noted a resident's fingernails to cleaning or cutting with daily care, then the PSW would provide care. RPN #101 indicated that there are some residents identified as cutting of

nails by registered nursing staff, but indicated resident #034 has not been identified as nail care by registered nursing staff.

The Associate Director of Care indicated, to Inspector #554, that PSW's are to provide fingernail care to residents on bath days, and or more frequently as need. Associate Director of Care indicated that nail care would be captured in the electronic care records.

The licensee failed to ensure that resident #034 received fingernail care, including the cutting of fingernails. [s. 35. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that residents receive preventative and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection; and that residents receive fingernail care, including the cutting of fingernails, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids**

**Specifically failed to comply with the following:**

**s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,**
**(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).**
**(b) cleaned as required. O. Reg. 79/10, s. 37 (1).**

**Findings/Faits saillants :**

The licensee failed to ensure that residents have their personal items, including personal aids, labelled within 48 hours of admission and acquiring new items.

During the initial tour of the long-term care home, Inspector #111 observed unlabelled and used personal care items belonging to residents in tub/shower rooms on all four resident home areas.

PSW #100, on one resident home area, indicated to Inspector #111 being unsure which resident the identified items belonged too.

During secondary observations, on an identified date, Inspector #554 observed unlabelled and used personal care items belonging to resident's tub/shower rooms on two identified resident home areas.

PSW's #105 and #131, both working on an identified resident home area, and PSW #138, who was working on another identified resident home area, indicated, to Inspector #554, that personal care items are to be labelled for individual use. All PSW's indicated being unaware of which resident the personal care items belonged to.

RN #107, Associate Director of Care, and the Director of Care indicated, to Inspector #554, that personal care items are to be labelled for individual resident use.

The licensee failed to ensure that residents have their personal items, including personal aids, labelled within 48 hours of admission and acquiring new items. [s. 37. (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 there is a process in place and monitored, ensuring that residents have their personal items, including personal aids, labelled within 48 hours of admission and acquiring new items, to be implemented voluntarily.***

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**WN #8: 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 :**

The licensee has failed to ensure that the interdisciplinary falls prevention and management program was implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

Related to Intake #001339-18:

A Critical Incident Report (CIR) was submitted to the Director on an identified date for a fall resulting in injury for which the resident was transferred to hospital and resulting in a significant change in condition. The CIR indicated that two days earlier, resident #022 sustained a fall, was injured and was later transferred to hospital.

Review of the licensee's policy, Fall Prevention, indicated under when a fall occurs: Registered staff will not move resident if there is suspicion or evidence of injury. The physician should be contacted and/or arrange for immediate transfer to the hospital. Complete a thorough investigation of fall incident including all contributing factors. Complete electronic post fall assessment by using the Post fall huddle or fall incident report.

The clinical health record, for resident #022, was reviewed specific to the incident which occurred.

RN #113 was interviewed by Inspector #111. RN indicated when a resident sustains a

fall, would go and assess the resident for any injuries. The RN indicated if there was a serious injury, resident would be sent to the hospital. The RN indicated that the nurse would not call the physician but would notify the SDM of the hospital transfer. RN #113 indicated receiving a call from the agency RPN #140, indicating resident was having discomfort. RN #113 indicated they were not notified that resident had fallen.

RPN #140 was interviewed by Inspector #111. RPN recalled resident sustaining a fall on an identified date. RPN #140 indicated notification of RN #113 specific to discomfort but not the fall. RPN #140 indicated that they did not document the fall and did not complete a post-fall assessment until five days following resident's fall.

The licensee has failed to ensure the falls prevention and management program was not implemented, as the RPN #140 did not report or document the fall incident the date which it occurred; and the RN #113 did not notify the physician or immediately transfer the resident to hospital.

2. The licensee has failed to ensure the interdisciplinary falls prevention and management program was implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

Review of the licensee's policy Fall Prevention, indicated under when a fall occurs: the DOC or designate will determine a communication process by which residents at moderate or high risk for falling are easily identified to the entire care team.

Related to Intake #001339-18:

A Critical Incident Report (CIR) was submitted to the Director for a fall resulting in injury that occurred on an identified date for which the resident #022 was transferred to hospital.

Review of the health care record for resident #022 indicated the resident was at high risk for falls.

RN #113 was interviewed by Inspector #111. RN #113 was uncertain if resident #022 was at high risk for falls.

Interview with the DOC by Inspector #111 indicated the expectation was that staff would discuss at nursing shift report any residents at high risk for falls. The DOC indicated the

licensee currently did not have any other communication process by which residents at moderate or high risk for falling were easily identified to the care team.

The licensee failed to ensure the interdisciplinary falls prevention and management program was implemented in the home, as there was no communication process by which resident # 022 who was at high risk for falling, was easily identified to the care team.

Related to Intake #016069-17:

Review of the health care record for resident #023 indicated the resident was at high risk for falls and sustained ten falls during an eight month period. One fall, on an identified date, resulted in injury.

Interview with RPN #106 and PSW #125 by Inspector #111, indicated they were both responsible for resident #023's care, RPN and PSW indicated that they were not aware resident's fall risk level, and interventions in place to prevent a fall.

Interview with the DOC by Inspector #111 indicated the expectation was that staff would discuss at nursing shift report any residents at high risk for falls. The DOC indicated the home currently did not have any other communication process by which residents at moderate or high risk for falling were easily identified to the care team.

The licensee failed to ensure the interdisciplinary falls prevention and management program was implemented in the home, as there was no communication process by which resident #023 who was at high risk for falling, was easily identified to the care team.

Related to Resident #005:

Interview with RPN #109 by Inspector #111, during stage one of the RQI, indicated resident #005 had sustained a fall in the last 30 days.

Review of the progress notes for resident #005 indicated the resident #005 had sustained a fall on an identified date, when the resident was found on the floor. Resident #005 was assessed by RPN #116, noted to have injury and was expressing discomfort. The RPN indicated the care plan was updated. The resident`s progress notes also indicated the resident had sustained two additional falls in the three months following this

fall.

Review of the written plan of care (for an identified date), indicated that resident #005 was at moderate risk for falls.

Interview with RPN #116 by Inspector #111, indicated usually after a resident has fallen, a post fall assessment is completed and the nurse updates the care plan. The RPN indicated resident #005 care plan was updated post fall on an identified date. Documents reviewed by Inspector #111 identifies that the written plan was not updated as indicated by the nurse. The RPN #116 indicated that they were not aware of any communication system in the home related to identifying residents at moderate to high risk for falls.

Interview with RPN #128 by Inspector #111, indicated that they was not aware of fall risk level for resident #005.

Interview with PSW #126 by Inspector #111, indicated resident #005 had a history of falls in the past but was now a low risk for falls. The PSW indicated that they were not aware of how fall risk was communicated.

Interview with RPN #125 by Inspector #111, indicated that they were the designate (lead) for the falls prevention committee. The RPN indicated resident #005 was not currently discussed at weekly meeting as resident was not identified as being at high or moderate risk for falls. RPN #125 was unaware of the communication process by which residents at moderate or high risk for falling were easily identified to the care team.

Interview with the DOC by Inspector #111 indicated the expectation was that staff would discuss at nursing shift report any residents at high risk for falls. The DOC indicated the licensee currently did not have any other communication process by which residents at moderate or high risk for falling were easily identified to the entire care team.

The licensee has failed to ensure the interdisciplinary falls prevention and management program was implemented in the home, as there was no communication process by which resident #005 who was at moderate risk for falling, was easily identified to the care team. [s. 48. (1) 1.]

2. The licensee failed to ensure that the following interdisciplinary programs were implemented in the home: a pain management program to identify pain in residents and manage pain.

Review of the licensee's Pain and Symptom Management Policy indicated under procedure, The Registered staff will: screen for presence of pain and complete a pain assessment when resident reports or exhibits signs and symptoms of pain (greater than 4/10 for 24-48 hours) and following implementation of pharmacological and/or non-pharmacological interventions. Make referral to appropriate interdisciplinary team members (i.e. MD, NP) and consider initiating Pain Study Tool for 24 hours or longer to assist with the assessment and evaluation of pain management when: pain remains regardless of interventions, a scheduled pain management regimen does not relieve pain.

Related to Intake #025331-17:

A Critical Incident Report (CIR) was submitted to the Director on an identified date for an injury for which the resident was taken to hospital and resulted in a significant change in condition. The CIR indicated that resident #011 was heard yelling and was found caught within a mobility aid. Four days later resident had diagnostic testing and was identified as having a specific injury.

The clinical health record for resident #011 was reviewed. The current written plan of care indicated the resident had discomfort related to a diagnosis, and that interventions included, administer routine or PRN (as needed) analgesic, not effects and document signs of discomfort.

Review of the electronic pain assessments indicated a pain assessment was completed on an identified date, indicated the resident had daily discomfort in an identified area. There was no documented evidence of a Pain Study Tool being completed.

Review of the progress notes for resident #011 during an identified period indicated resident was experiencing discomfort, and actions taken by registered nursing staff. Interview with RPN #134 by Inspector #111, confirmed the pain policy was not complied with for the incident that occurred on an identified date as: the incident was not documented or reported until the next day and no pain assessment was completed.

The licensee failed to ensure the Pain and Symptom Management Policy was complied with.

Related to Intake #001339-18:

A Critical Incident Report (CIR) was submitted to the Director for a fall resulting in injury that occurred on an identified date for which the resident was transferred to hospital.

Interview with RN #113 and RPN #134 by Inspector #111, indicated resident #022 received routine analgesic but did not receive any additional analgesic on the identified date after the fall and when resident complained of discomfort. The RN and RPN confirmed there was no pain assessment completed.

The licensee failed to ensure the Pain and Symptom Management Policy was implemented for resident #022 as the staff did not complete a pain assessment when resident sustained a fall with injury and no additional analgesic was offered when the resident complained of pain. [s. 48. (1) 4.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that an interdisciplinary falls prevention and management program is implemented in the home, with the aim to reduce the incidence of falls and the risk of injury, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following:**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

The licensee failed to ensure that the plan of care, specific to promoting and managing bowel continence, was implemented for resident #034 who is assessed to be incontinent.

On an identified date during this inspection, resident #034 indicated, to Inspector #554, that continence care had not been provided. Resident #034 indicated they approached RPN #101, on the identified date at an identified time to request continence care.

Resident #034 indicated they approached a nursing student, approximately 30 minutes following the initial request to RPN #101, to voice concern that continence care not been provided. Resident #034 indicated nursing student's advice was to wait for staff. Resident #034 indicated they had waited for an hour for care to be provided, indicated calling the Associate Director of Care who said they were unavailable to assist with care at that time. Resident #034 indicated being frustrated, and indicated leaving the resident home area and going outside for 10-15 minutes before returning to the unit. Resident #034 indicated that breakfast was being served upon their return to the resident home area, resident indicated being too upset to eat. Resident #034 indicated continence care was not provided until an identified time, which was 2.5 hours following resident's initial request for care.

The Associate Director of Care, and the Director of Care indicated that resident #034's continence care had not been provided as resident left the resident home area following the initial care request.

The clinical health record, for resident #034, was reviewed. The review indicated the following:

- Resident #034 is assessed as being incontinent.

Written Care Plan (current at the time of this inspection):
- Toileting – requires assistance. Interventions include two staff to provide extensive assistance; resident is incontinent, wears continence product; resident is competent to know when continence product needs to be changed and will notify staff.
- Incontinence – containment. Goal of care is to be clean, dry and odour free. Interventions include staff to change continence product when resident notifies them of need for assistance.

RPN #101 indicated, to Inspector #554, that they were aware that resident #034 needed continence care on the identified date. RPN indicated that resident had requested care at a specific time. RPN #101 indicated that PSW #136 was notified of resident #034's need

for continence care. RPN #101 indicated PSW #136 and PSW #108 indicated that care would be provided to resident #034 following care being provided to another resident. RPN #101 indicated that no follow up was done to ensure care of resident #034's had been completed.

Practical Nursing Student, who was working with RPN #101 on the identified date, indicated, to Inspector #554, that resident #034 approached, voiced frustration and was visibly upset that continence care had not been provided. Practical Nursing Student indicated it was approximately 20 minutes following resident's initial request to RPN #101. Practical Nursing Student indicated being aware that RPN #101 had already communicated care needs, of the resident, to the PSW's, and indicated telling resident #034 to wait for staff to provide care. Practical Nursing Student indicated that no follow up was done to ensure care of resident #034 had been completed.

PSW #136 indicated, to Inspector #554, that they were aware that resident #034 had been incontinent and in need of care. PSW indicated being told by RPN #101 of resident #034's care needs at an approximate hour (same time, as indicated above by RPN #101). PSW #136 indicated telling resident #034, at that time, that care would be provided once they (PSW's #108 and #136) were finished caring for a co-resident. PSW indicated that care was not provided to resident #034 following care of the co-resident as communicated, as they were busy with other residents.

PSW #108 indicated, to Inspector #554, that they were aware that resident #034 had been incontinent and in need of care. PSW indicated being present with PSW #136, when PSW #136 was told by RPN #101 that resident #034 needed care. PSW #108 indicated the time of the direction by RPN #101. PSW #108 indicated that they (PSW #108 and #136) were providing care to a co-resident at that time, and PSW #136 told resident #034 that care would be provided following. Personal Support Worker #108 indicated being busy with morning routine, and that they must have forgotten to return to care for resident #034. PSW #108 indicated that resident #034 approached again about care not being provided approximately 45 minutes following resident's initial request to RPN #101, but at that time the priority was getting resident into the dining room for breakfast. PSW #108 indicated care was not provided to resident #034 at that time.

PSW's #108 and #136, as well as RPN #101 indicated they were aware that resident #034 was upset that continence care had not been provided. All indicated resident left the resident home area approximately an hour after resident's initial request for care. PSW's #108 and #136 indicated that resident #034 approached them again at some

point during the breakfast meal to voice frustration about care not being provided. Both PSW's indicated that care was not provided at that time, as their priority was assisting residents with breakfast.

PSW's #108, and #136, Practical Nursing Student and RPN #101 indicated that resident #034 was not provided continence care for 2.5 hours following their initial request for care.

Resident #034 indicated that they were frustrated with the length of time it took staff to provide care on the identified date and indicated that this is not the first occurrence, of this nature, where care has not been provided for some time after an initial request to staff.

The licensee failed to ensure that the plan of care, specific to promoting and managing bowel continence, was implemented for resident #034 on an identified date during this inspection. [s. 51. (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 there is a process in place and monitored, ensuring that the plan of care, specific to promoting and managing bowel continence, was implemented for resident #034 who is assessed to be incontinent, to be implemented voluntarily.***

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**WN #10: 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,**
**(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).**

**Findings/Faits saillants :**

The licensee failed to ensure that procedures are developed and implemented for addressing incident of lingering offensive odours.

During the initial tour of the long-term care home, Inspector #111 identified incidents of lingering offensive odours throughout the home, specifically inside a tub/shower room located on one resident home area, and outside of three identified resident rooms on two identified resident home areas.

Building Services Aid #103, and Building Services Manager indicated, to Inspector #554, that there is cleaning procedures in place when lingering offensive odours are identified. Both indicated that resident rooms and common areas on listed on daily cleaning schedules. When odours are identified an investigation will commence to determine the cause of the odour, and efforts will be taken to resolve the odour, including use every day disinfectants, enzymatic agents, odour reducing sponges, and bounce sheets. Building Aid #103 indicated some areas which present challenges with odour elimination may be cleaned twice daily as per direction from Building Services Manager. Building Services Manager indicated there are five resident rooms in the home, with identified odours, where flooring is scheduled for replacement; Building Services Manager indicated that rooms scheduled for replacement did not include the identified tub room or three identified resident rooms.

During seven identified dates during this inspection, lingering offensive odours were identified by Inspector #554, in one identified resident room on an identified resident home area. Lingering offensive odours were noted throughout the day, specifically during the hours of 0800 hours to 1430 hours.

During two identified dates during this inspection, a soiled urinal was observed, by Inspector #554, on the toileting bar in an identified resident washroom, and paper towels were observed on the floor in front of the toilet, of the identified resident room. On an identified date, dark brown stains were observed smeared on the flooring and on the transfer device used by resident #038, who resides in the identified room. It is to be noted that this room is shared by two residents.

Building Service Aid #103 indicated, to Inspector #554, being aware of the lingering offensive odour in identified resident room/washroom. Building Service Aid indicated that the odour has been present in the identified resident room for a while (undetermined time) and indicated the lingering offensive odour is due to the two residents in the room toileting and or continence care habits. Building Service Aid #103 indicated that the 'urine

remains on the floor for hours before Building Service Aid can attend to it'. Building Service Aid #103 indicated that the identified resident room/washroom is cleaned once daily.

PSW's #104, #136 and #154 indicated, to Inspector #554, that the lingering offensive odour in the identified resident room/washroom, is always present. All three PSW's indicated that the odour is likely due to both resident's spilling 'urine' on the floor. PSW's #104, #136 and #154 indicated that resident #054 'spills urine on the floor that it remains on the floor until building services cleans the room. PSW's #104, and #154 indicated that resident #038 'spills urine on the floor when resident empties urinal into the commode' which is located at resident's bedside; PSW indicated that the commode sit's at the resident's bedside until staff can empty its contents.

Building Services Manager indicated that there are procedures in place, specifically cleaning processes, use of disinfectants, enzymatic agents, and sponges to address lingering offensive odours, but such does not address issues with resident care, or responsive behaviours both of which is related to odours present in the identified resident room.

The plan of care for resident #038 and #054 were reviewed for a period of three months. The review failed to provide support that procedures were developed and/or implemented to address incidents of lingering offensive odours, specific to continence care and bowel care management.

The licensee failed to ensure that procedures are developed and implemented for addressing incident of lingering offensive odours, specifically in an identified resident, located on an identified resident home area. [s. 87. (2) (d)]

***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 there is a process in place and monitored, ensuring that procedures are developed and implemented for addressing incident of lingering offensive odours, to be implemented voluntarily.***

**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

Related to Intake #009992-17:

A Critical Incident Report (CIR) was submitted to the Director for a suspected resident to resident physical abuse incident, involving residents #047 and #48. The CIR indicated on an identified date, staff heard yelling and a thump from the hallway and found resident #047 standing over resident #048. Resident #048 sustained injury related to this incident; resident was unable to indicate how the injuries occurred. The CIR was completed by the ADOC.

The CIR did not indicate both SDMs were notified of the outcome of the home's investigation.

Interview with the ADOC by Inspector #111 indicated the SDM of resident #047 was notified of the outcome of the investigation the next day, but had no documented evidence to indicate the SDM of resident #048 was notified of the outcome of the investigation. [s. 97. (2)]

2. Related to Intake #017137-17:

A Critical Incident Report (CIR) was submitted to the Director for a suspected resident to resident physical abuse incident, involving residents #047 and #048. The CIR indicated on that on an identified date, resident #047 was found inside a doorway with fists clenched, and that resident #048 was found standing on opposite side of hallway with

visible injuries. Resident #047 reported that they had hit resident #048. Resident #047 reported that they were pushed by resident #048. There was no indication the SDMs were notified of the outcome of the investigation upon completion. The CIR was completed by the ADOC.

Interview with the ADOC by Inspector #111 indicated the SDM of resident #047 was notified of the outcome of the investigation the same day of the incident, but had no documented evidence to indicate the SDM of resident #048 was notified of the outcome of the investigation.

The licensee failed to ensure resident #048's SDM was notified of the results of the alleged abuse investigation immediately upon the completion. [s. 97. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being; and that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion, to be implemented voluntarily.***

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.**

**Findings/Faits saillants :**

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

Related to Intake #021470-17:

The Director of Care submitted a Critical Incident Report (CIR) to the Director on an identified date. The CIR was related to an alleged incident of resident to resident physical abuse involving residents #029 and #030. The alleged abuse occurred two days earlier.

The CIR, indicates resident #030 reported the allegation to a PSW, who reported allegation to RPN #152, who intern reported the allegation to RN #151, who was the assigned Charge Nurse.

RPN #152 indicated, to Inspector #554, that the alleged abuse was reported to Charge Nurse-RN #151, the day of the alleged abuse.

RN #151 was unavailable for an interview during this inspection.

The Director of Care indicated, to Inspector #554, that management first became aware of this incident while reading report two days following the alleged abuse. The Director of Care indicated that police were notified of the alleged abuse two days following the alleged abuse incident. The Director of Care indicated that abuse of a resident resulting in an injury is reportable immediately to the police.

The licensee failed to ensure that Charge Nurse-RN #151, who was the designate of the licensee, immediately notified the police of an alleged resident to resident abuse which involved residents #029 and #030. [s. 98.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.***

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**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,**
**(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and**
**(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).**

**Findings/Faits saillants :**

1.The licensee failed to ensure the Director is informed of, an incident that causes an injury to a resident for which the resident is taken to hospital and that results in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident, followed by the report.

Related to Intake #025331-17:

A Critical Incident Report (CIR) was submitted to the Director, on an identified date, for an injury for which resident #011 was taken to hospital and resulted in a significant change in condition. The CIR indicated the incident occurred 10 days earlier, resident #011 sustained injury as a result of this incident.

The DOC indicated, to Inspector #111, that the Director was not notified of the incident for 10 days.

The ADOC indicated, to Inspector #111, that the incident occurred on an identified date, and indicated that resident #011 was transferred to hospital, five days following the incident. ADOC indicated the injury to resident #011 resulted in a significant change in condition of the resident. ADOC confirmed that the CIR was not submitted for 10 days post incident, and/or five days following resident’s transfer to hospital.

The licensee has failed to ensure the Director is informed of, an incident that causes an injury to resident #011, for which the resident is taken to hospital and that results in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident, followed by the report. [s. 107. (3.1)]

***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 there is a process in place and monitored, ensuring that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report, specifically, an incident that causes an injury to a resident for which the resident is taken to hospital and that results in a significant change in the resident's health condition, to be implemented voluntarily.***

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**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

**Specifically failed to comply with the following:**

**s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,**
**(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).**
**(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).**

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

**s. 135. (3) Every licensee shall ensure that,**
**(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).**
**(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).**
**(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).**

**Findings/Faits saillants :**

The licensee has failed to ensure that every medication incident involving a resident was (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Review of the individual medication incidents for a three month period indicated:

- Resident #039 was not administered four medications as prescribed on an identified date. The incident report indicated the physician was notified but not the SDM. Review of the progress notes had no documented evidence the SDM was notified.

Interview with the DOC by Inspector #111 indicated the medication incident would have been reported to resident #039's SDM, but could not indicate which staff member reported the incident to the SDM and had no documented evidence to support this.

The SDM of resident #039 indicated, to Inspector #111, having no awareness of the medication incident.

- Resident #042 was provided with medications not prescribed on an identified date. The incident report did not indicate which medications were given in error or who the RN was that was involved. The incident report indicated the SDM was not informed. Progress notes reviewed, for resident #042, had no documented evidence of an assessment of the resident or any indication that the SDM was notified of the resident receiving the wrong medications or medications given in error. The spreadsheet provided by the DOC, during this inspection, indicated the ADOC followed up with an "agency RN". The document provided no indication of which RN was involved.

Interview with the ADOC, by Inspector #111 during this inspection, indicated no awareness of the medication incident involving resident #042, no awareness of ever speaking to any agency RN regarding this incident, and they had no awareness of who the RN involved was.

- Resident #041 had an order to discontinue an identified medication on an identified date. A medication incident report was completed on an identified date 20 days later, and indicated the incident occurred on an identified date (one day prior to incident report being completed). The incident report did not indicate when the transdermal medication was actually removed. Review of the health record of resident #041 had no documented evidence of the medication incident to indicate that the resident was assessed and information related to why the incident was a medication incident. The spreadsheet provided by the DOC, during this inspection, indicated RPN #106 was involved in the incident.

Interview with RPN #106, by Inspector #111 during this inspection, indicated the DOC never discussed the medication incident involving resident #041 with the RPN. Interview with the DOC by Inspector #111, indicated no awareness why the incident report was not submitted for 20 days after the medication was discontinued or when the resident's transdermal medication was actually removed.

The licensee has failed to ensure that every medication incident involving resident #039, #041 and #042 was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

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

Review of the individual medication incidents from a three month period indicated:

- Resident # 046 was not administered an identified medication on an identified date. The DOC indicated on the incident report that she followed up with the agency staff. There was no name identified to indicate which agency staff or when the follow up occurred.

The spreadsheet provided by the DOC, during this inspection, indicated no follow with the nurse because the nurse did not return to the home. There was no indication which agency RPN was involved.

Interview with the DOC by Inspector #111 indicated they were unable to provide the name of the agency RPN and had no documented evidence to support when or which agency nurse the DOC spoke with. During a second interview the DOC indicated the staff member involved in the incident was agency RPN #144 but had no documented evidence to support that corrective actions was taken with this agency nurse or when.

- Resident #042 was provided with another residents medications on an identified date by an RN. The incident report did not indicate which medications were given in error or by whom. The incident report indicated the SDM was notified. Review of the resident's progress notes had no documented evidence of an assessment of the resident or any

indication the SDM was notified of the resident receiving the wrong medications or which medications were given in error.

The spreadsheet provided by the DOC, during this inspection, indicated the ADOC followed up with an agency RN #143. The DOC indicated the staff member involved in the incident was agency RPN #144.

Interview with the ADOC by Inspector #111, indicated no awareness of incident, no awareness of speaking to any agency nursing staff regarding this incident, no awareness of which medications were given in error or which agency RN/RPN was involved.

- Resident #041 had an order to discontinue an identified medication on an identified date. The incident report was completed on 20 days later and indicated the incident occurred a day prior to the date of the incident report. The incident report did not indicate when the transdermal medication was actually removed. Review of the health record of resident #041 had no documented evidence of the medication incident to indicate the resident was assessed or any information related to when the medicated patch was actually removed.

The spreadsheet provided by the DOC, during this inspection, indicated the DOC provided re-education to RPN #106 who was involved in the incident regarding checking and transcribing orders.

Interview with the DOC by Inspector #111, indicated no awareness why the incident report was not submitted for 20 days after the medication was discontinued, when the resident's transdermal medication was actually removed or when actions were taken with RPN #106.

Interview with RPN #106 by Inspector #111, indicated the DOC never discussed re-education related to the medication incident involving resident #041 and was not involved in the medication incident. The RPN indicated they became aware of the incident by the RN who reported: the SDM discovered the transdermal medication was still present on the resident approximately two weeks after the transdermal medication was discontinued when the SDM was preparing the resident for their bath.

The licensee failed to ensure that all medication incidents that were documented, were reviewed, analyzed and corrective actions were taken as necessary, and a written record was kept of this. [s. 135. (2)]

3. The licensee has failed to ensure that, (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes and improvements identified in the review are implemented, and (c) a written record is kept of everything provided for in clause (a) and (b).

During the RQI process, a review of three months medication incidents were reviewed.

Interview with the DOC by Inspector #111, indicated a quarterly review of medication incidents is completed at the interdisciplinary Professional Advisory Committee (PAC) meetings. The DOC indicated the DOC, RD, physician, pharmacist, Administrator, ADOC and BSO lead attended the meetings. The DOC indicated the last meeting occurred on an identified date in 2018 and reviewed medication incidents from three months, and that they utilize an identified report (by a third party) as part of the review.

Review of the Professional Advisory Committee meeting minutes (identified date) indicated current medication errors were discussed and being tracked for trends by the home, the home utilized the identified report online which summarized the monthly medication incidents reported and the medication incidents review period of three months. The medication incident summary indicated (identified report) indicated there were three medication incidents involving residents for an identified date in 2017, two medication incidents involving residents for identified date in 2017 and two medication incidents involving residents for an identified date in 2018. This review did not identify which residents, staff, units were involved in the medication incidents to identify trends and did not identify any changes and improvements made since the last review in order to reduce and prevent medication incidents.

The DOC was interviewed by Inspector #111. The DOC was made aware, by Inspector #111 that the identified report and PAC meeting minutes did not identify trends or any changes and improvements in the review to prevent medication incidents; DOC then provided a spreadsheet that contained additional information, which included staff involved and actions taken specific to the incident. The spreadsheet was not signed to indicate when it was created and still did not provide changes or improvements identified to prevent all medication incidents. The DOC indicated at that time, actions taken were also discussed at the monthly registered staff meetings but the minutes were never provided to Inspector #111.

The licensee failed to ensure that a quarterly review was undertaken of all medication incidents that had occurred in the home during an identified three month period in order to reduce and prevent medication incidents, and a written record was kept of any changes and improvements identified in the review that were implemented. [s. 135. (3)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that every medication incident involving a resident has been documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider; that all medication incidents and adverse drug reactions are documented, reviewed and analyzed; that corrective action is taken as necessary; and that a written record is kept of everything required under clauses (a) and (b) of the legislation; and that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review are implemented; and that a written record is kept of everything provided for in clause (a) and (b), to be implemented voluntarily.***

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**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program.

During two identified dates during this inspection, personal care items were observed in tub/shower rooms in all resident home areas. Identified personal care items were observed by Inspector #111 and #554 to be used. The identified personal care items were not identified as belonging to any specific resident.

PSW's #105, #131, and #138 indicated, to Inspector #554, that the personal care items in tub/shower rooms are for 'general use', and indicated that general use meant 'used by staff for any resident needing nail care'.

PSW's #105, #131, and #138 indicated that they do not know of any policy or procedure in place for cleaning and/or disinfection of the identified personal care items following use.

RN #107, who is the Lead for Infection Prevention and Control, the Associate Director of Care (ADOC), and the Director of Care (DOC), all indicated that the identified personal care items are for individual resident care and are not to be shared.

The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program, specific to the use of nail clippers for resident care.

2. On two identified dates, a soiled continence product was observed on the floor outside the washroom of an identified resident room, on an identified resident home area.

On an identified date, separate occasion, a soiled continence product was observed on the floor of an identified resident room, on an identified resident home area.

PSW's #104, and #154 indicated, to Inspector #554, that they place soiled continence products on floors as they have no other place to place the soiled product while providing care to residents.

The ADOC, and the DOC indicated that soiled continence products are to be placed into the garbage bags, taken out of resident room, placed into waste receptacles in the hallway, and then taken to the soiled utility rooms for disposal. Both ADOC and DOC indicated that soiled products are not to be placed on floors.

The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program, specific to the handling and disposal of soiled continence products.

3. During the initial tour of the long-term care home, Inspector #111 observed yellow personal protective equipment (PPE) bags hanging from the doors of three resident rooms, all located within the same resident home area. Inspector #111 did not observe any signage indicating the type of precaution in place for resident's residing in the identified rooms.

RPN #101 indicated, to Inspector #111, that the resident residing in an identified room was under a specific precaution.

On an identified date Inspector #554, observed that two identified resident rooms, on the identified resident home area, had yellow PPE bags hanging on the doors; there was not signage, on the doors of the identified rooms, to direct staff and or others entering the rooms as to the type of precaution to take.

PSW's #104, and #105, who both work on identified resident home area, indicated being unaware of the precaution to take, and or to wear PPE when entering the two identified resident rooms.

RPN #106, who was the unit supervisor for the identified resident home area, indicated to Inspector #554 that it is the role of the night staff to ensure precaution signage is in place. RPN #106 indicated if signage wasn't in place, staff could ask for direction as needed related to use of PPE. RPN #106 indicated that resident #034, residing in an identified room, and resident #038, residing in another identified room were both identified as needing an identified precautions.

RN #107, who is the Lead for Infection Prevention and Control, indicated, to Inspector #554, that registered staff working the night shift are responsible to ensure that signage and supplies are in place for residents as identified as being in isolation and/or under precautions, but further indicated all staff are responsible to ensure that the same is in place.

On two identified dates, an identified resident room did not have precautionary signage in place, despite an identified precaution being in place for resident #038.

The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program, specific to the precautionary measures to be taken.

4. During the initial tour of the long-term care home, Inspector #111 observed that two resident rooms, on an identified resident home area, were identified as being in an identified precaution.

On an identified date, Inspector #554 observed that three resident rooms were identified as being in an identified precaution, signage was posted on the identified doors, and PPE yellow bags were hung on the doors of these rooms.

The precautionary signage on each of the identified rooms indicated that the required PPE's, which included gown, gloves, mask with visor (or goggles), were to be worn by staff or others when they were within two meters of resident.

The required PPE, specifically masks with visors, and/or goggles were not available in the PPE bags for use by staff and or others entering the identified rooms.

PSW's #104 and #105 indicated, to Inspector #554, being aware of precautionary measures to take for the identified precaution, but indicated that no masks with visors or goggles were available for use. PSW's #104 and #105 both indicated that care had been provided to resident's residing in the three identified rooms, using the PPE's they had available. PSW #105 indicated that often supplies are not available for use, and when they tell registered nursing staff they are told that they do not have supplies

RPN #106, who is the unit supervisor on the identified resident home area, indicated, to Inspector #554, awareness that the required equipment were available for staff and others entering the identified rooms. RPN #106 indicated that it is the responsibility of the night registered staff to ensure adequate supplies, including PPE's are available for use on each resident home area.

RN #107, who is the Lead for Infection Prevention and Control, indicated, to Inspector #554, that it is the role of the night registered staff to ensure adequate supplies are brought to the resident home areas, but all staff can obtain supplies as needed. RN #107 indicated staff are expected to wear the indicated PPE to protect themselves and the residents. RN #107 indicated being unaware of any PPE supply shortages in the home, and indicated staff just have to ask and supplies will be provided as needed. RN #107 indicated that the required equipment was available in a supply room.

The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program, specific to the precautionary measures to be taken when infection control and prevention precautions have been identified. [s. 229. (4)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.***

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**Issued on this 4th day of October, 2018**

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

**Original report signed by the inspector.**