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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Dec 17, 2018	2018_587129_0009 (A1)	018704-18	Resident Quality Inspection

Licensee/Titulaire de permis

Barton Retirement Inc.
1430 Upper Wellington Street HAMILTON ON L9A 5H3

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

The Wellington Nursing Home
1430 Upper Wellington Street HAMILTON ON L9A 5H3

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

Amended by PHYLLIS HILTZ-BONTJE (129) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

This Report has been amended in order to adjust the compliance date for order #001 (s. 8(1)) to April 30, 2019

Issued on this 17th day of December, 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

Amended by PHYLLIS HILTZ-BONTJE (129) - (A1)

Amended 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): July 26, 27, 30, 31, August 1, 2, 3, 7, 8, 9, 10, 13, 14, 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 29, 30, 2018.

The following complaint inspections were completed concurrently with this

Resident Quality Inspection (RQI):

Log #003224-18-related to oral care, skin and wound, allegation of abuse and plan of care.

Log #008677-18-related to bathing/staffing.

Log #011352-18-related to complaints, allegation of abuse, resident's rights, plan of care, transferring and positioning.

Log #018379-18-related to continence care, skin and wound, transferring and positioning, dining and snack service, bathing, protection from restraining and allegation of abuse.

Log #018479-18-related to nutritional care, administration of drugs, continence management, allegation of abuse.

Log #000796-18-related to transfers.

Log #008123-18-related to family visitation and resident rights

Log #019798-18- related to transfers, allegation of abuse, menu planning, care, laundry and housekeeping.

The following Critical Incident inspections were completed concurrently with this RQI:

Log #008973-17-related to transfer, positioning, prevention of abuse.

Log #017136-17-related to a fall.

Log#002792-18-related to a fall.

Log #009168-18-related to missing controlled substance.

Log #027495-17-related to controlled substance unaccounted for.

Log #007787-18-related to controlled substance unaccounted for.

Log #029456-17-related to transfer.

Log #018154-18-related to staffing, bathing, continence care, allegation of abuse and falls.

During the course of the inspection, the inspector(s) spoke with residents, resident family members, representatives of Resident Council and Family Council, Personal Support Workers, housekeeping staff, dietary staff, Registered Nurses, Physiotherapists, Social Worker, Registered Dietitian, Food Service Manager, Assistant Director of Care, Director of Care and the Administrator.

During the course of this inspection, Inspectors observed resident care, observed meal service, reviewed resident's paper and computerized clinical records, reviewed minutes recorded for the Resident's Council and Family Council meetings, observed medication administration and medication storage practices, made observations of resident's environment, observed infection prevention and control practices and reviewed licensee policies related to: Continence Care and Bowel Management, Nutritional Care and Assessment, Skin and Wound Care, Falls Prevention and Management, Medication Administration and Management of drug supply as well as Infection Prevention and Control policies.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **17 WN(s)**
- **9 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any

plan, policy, protocol, procedure, strategy or system that the plan, policy, protocol, procedure, strategy or system was complied with.

A) The licensee failed to ensure that policies included in the organized program of nursing services were complied with.

In accordance with the Long Term Care Homes Act (LTCHA) 2007, c. 8, s. 8(1)(a) the licensee is required to ensure there is an organized program of Nursing Services for the home to meet the assessed needs of the resident and in accordance with O. Reg. 79/10, s. 30 (1) 1, the licensee is required to ensure that each of the organized programs include policies, procedures and protocols.

1. The licensee's policy identified as NUR-V-75 with a revised date of March 2018 and included in the Nursing Manual, provided directions for registered staff, which included instructions to document the procedure in the resident's electronic record when the identified medical device was changed.

a. The plan of care for resident #043, stated that for a two year period of time the resident used the identified medical device that was to be changed at a specified interval. The Treatment Administration Record (TAR) was reviewed and initialled by registered staff to indicate the medical device had been changed on an identified date in April, May, July, August and October 2017.
A review of the electronic clinical notes confirmed that the procedure for changing the medical device had not been documented in the electronic record on an identified date in April, May, July, August and October 2017, as required by policy.

It was confirmed in an interview with the Director of Care (DOC) on an identified date, that registered staff failed to document the medical device changes on the identified dates and that the licensee's policy identified as NUR-V-75 had not been complied with. (130)

(PLEASE NOTE: This non-compliance was issued as a result of Complaint Inspection #003224-18, which was conducted concurrently with the RQI.)

b. On an identified date, resident #031 was admitted to the home with an identified medical device and a review of the admission orders directed registered staff to change the medical device at a specified interval. The TAR was reviewed and identified that the medical device had been changed on an identified date in

July 2018.
A review of the progress notes documented in the electronic clinical record, identified there were no notes recorded describing the procedure that was done, the assessment of the resident nor the resident's response to the procedure.

During an interview with the DOC on an identified date, it was confirmed that on the identified date in July 2018, registered staff failed to ensure that the licensee's policy was complied with. (581)

(PLEASE NOTE: This non-compliance was issued as a result of Complaint Inspection #0018154-18 related to IL-58170-HA, which was conducted concurrently with the RQI.)

2. The licensee's policy identified as NUR-V-254, revised February 2001, directed staff to chart the procedure on the nursing record; indicate colour, odour, quantity and pertinent observations. The policy identified as NUR-V-252, revised February 2018, stated all laboratory specimens that are collected would be tested first on site.

The clinical record of resident #053 contained a progress note documented on an identified date in 2018, made by registered staff #117, which stated a laboratory specimen was obtained. The clinical note did not include the procedure nor did it specify whether or not the specimen was tested first on site.

Registered staff #117 confirmed in an interview on an identified date, that they had not document the procedure for obtaining the specimen and that they had not perform the test before sending the specimen to the laboratory.

The licensee's policy identified as NUR-V-254 and NUR-V-252, were not complied with. (130)

(PLEASE NOTE: This non-compliance was issued as a result of Complaint inspection: 018479-18, which was conducted concurrently with the RQI.)

3. The licensee failed to ensure that the policy identified as NUR-VI-43, dated March 2005 and located in the Nursing Policy and Procedure Manual was complied with.

The above noted policy directed the following:
-Each resident's identified personal care items must be labelled with the individual resident's name,
-Each resident's identified personal care items are emptied, rinsed and cleaned after each use,
-Individual personal care items that are used by a resident, are kept in the resident's room in an identified location, when not in use.

On an identified date, while completing stage 1 of the Resident Quality Inspection (RQI), observations were made in resident's rooms by Inspector 129. It was noted by the Inspector that there were soiled, unlabelled personal care items not stored in the identified locations in three identified resident rooms.

The above noted observations were shared with the DOC and on an identified date the Inspector and the DOC toured the two home areas where it was observed that soiled, unlabelled personal care items were again noted to not be stored in the required locations in four identified rooms.

The DOC confirmed that staff had not complied with the licensee's policy noted above when they did not label personal care items with resident's individual names, did not rinse and clean personal care items after each use and did not store the personal care items in the designated locations, when not in use. (129)

B. The licensee failed to ensure policies included in the organized program of Nutrition Care and Dietary Services, were complied with.

In accordance with the Long Term Care Homes Act (LTCHA) 2007, c. 8, s. 11(1) (a) the licensee is required to ensure there is an organized program of Nutrition Care and Dietary Services for the home to meet the daily nutrition needs of the residents and in accordance with O. Reg. 79/10, s. 30 (1) 1, the licensee is required to ensure that each of the organized programs include policies, procedures and protocols.
.
The licensee's policy "Quarterly Nutritional Review Assessment", identified as NFS-III-07 with a revised date of January 2002, located in the Nutrition and Food Service Manual, stated that all residents would have a quarterly nutritional assessment and the results of the quarterly nutritional review would be communicated to all members of the Health Care Team.

According to the plan of care, resident #053 was assessed at a nutritional risk. A quarterly review assessment completed by the Food Service Supervisor (FSS) on and identified date in 2017, stated the resident's intake was below their recommended daily intake. The Registered Dietitian (RD) confirmed in an interview on an identified date, that the results of this quarterly assessment were not communicated to them. The coding completed during the following quarterly review time period, triggered a Resident Assessment Protocol (RAP) for an identified concern. The RAP stated the resident had consumed less that their daily recommended intake. The remainder of the nutritional RAP summary was incomplete. There were no referrals made to the RD to assess the potential identified concern and there were no objectives specified when the resident's intake fell below the recommended daily intake. The RD confirmed in an interview on an identified date, that a nutritional quarterly assessment was not completed in February 2018 and that they were not informed when the resident's intake was below their recommended daily intake in November 2017 and February 2018.

The licensee's policy "Quarterly Nutritional Review Assessment, NFS-III-07, revised on January 2002, was not complied with. (130)

(PLEASE NOTE: This non-compliance was issued during Complaint inspection #018479-18, which was conducted concurrently with the RQI.)

C. The licensee failed to ensure policies included in the Medication Management System were complied with.

In accordance with O. Reg. 79/10, s. 114 (2) the licensee is to ensure written policies and protocols were 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.

1. The licensee failed to ensure the policy "Destruction and Disposal of Narcotic and Controlled Substances", identified as #3.3.19., with a revised date of March 2018, located in the Pharmacy Policy and Procedure was complied with.

While completing Critical Incident System (CIS) #0091680-18 inspection, related to Critical Incident Report (CIR) #2784-0000006-18, which had been reported to the Director as an incident of missing/unaccounted for controlled substances, the

DOC was asked to provide the licensee's policy that identified the process to be followed by registered staff when disposing of a narcotic or controlled substance. In response the DOC provided the above title policy and verified that the above noted policy was the policy staff were expected to follow when dealing with the destruction and disposal of narcotic and controlled substances.

This policy directed:
"Loose narcotic medications such as pills that a resident has refused, is not able to swallow, or are not administered due to hospitalization etc., must be wasted by two nurses to complete the waste process.
The waste process includes:
-The waste must be documented on the Combined Monitoring Medication Record with Shift Count under the section "wasted".
-A photocopy of the individual count sheet must be made, and placed along with the medication being wasted into a zip lock bag provided in the medication room.
-The sealed zip lock bag (containing the copied count sheet and the medication) is placed in the narcotic destruction box located in the medication room on the first floor."

The above noted policy was not complied with when RPN #144 and RPN #106 did not follow the above noted directions when they wasted three identified tablets on an identified date in 2018.
During an interview with the Assistant Director of Care (ADOC), they identified that while completing control substance count, RPN #144 and RPN #106 wasted three identified tablets that were no longer required by placing them in an identified container. This incident had been discovered when the ADOC and the Pharmacist completed the process for controlled drug destruction.

The ADOC confirmed that they immediately launched an investigation when they found the controlled substance in the identified container and during their investigation into this incident they interviewed RPN #106 who confirmed that at the time of the incident they had consulted with RPN #144 and the identified tablets were placed in the identified container.

The ADOC verified that when they interviewed RPN #106 following the incident, RPN #144 confirmed that wasting controlled substances by putting them into the identified container was a practice in the home.

The ADOC and a CIR submitted to the Director confirmed that the licensee's

policy "Destruction and Disposal of Narcotic and Controlled Substances" had not been complied with.

(PLEASE NOTE: The above noted no-compliance was related to compliance with the licensee's policies was identified while inspecting Critical Incident Inspection #009168-18 related to Critical Incident Report # 2784-000006-18.)

2. The licensee failed to ensure the policy "Narcotic and Controlled Medication", identified as policy 6.2., with a revised date of March 2018 and was located in the Pharmacy Policy and Procedure Manual, was not complied with.

While completing CIS #027495-17 inspection, related to CIR #0784-000017-17, which had been reported to the Director as an incident of missing/unaccounted for controlled substances, the DOC was asked to provide the licensee's policy and verified that the above noted policy was the policy staff are expected to follow for the storage of controlled substances.

a) This policy directed:
"Narcotic and controlled substances that have been discontinued or for a resident that has deceased are stored in a designated locked area for such storage, along with the Resident Controlled Substance Count Sheet. Only the DOC (designate) and the Pharmacist shall have a key to this storage area."

During an interview with the DOC and the ADOC they confirmed that on an identified date in 2017, it was identified that 10 vials of a drug identified as a controlled substance had been removed from the designated locked area that had been designated to store these drugs.
During the above noted interview the DOC confirmed that they had not complied with the policy that directed only the DOC (delegate) and the Pharmacist would have keys and access to the designated storage area when prior to identified incident in 2017, the keys to this designated area were kept in the DOC's office and other identified staff had access to the keys to unlock the designated storage area.

b) This policy directed:
"Any discrepancy in narcotic and controlled drug count is reported immediately to the DOC. The DOC shall attempt to reconcile all reported discrepancies. The DOC shall submit a report to the administrator for irreconcilable differences"
"If a major discrepancy or a pattern of discrepancies occurs, the DOC shall notify

the administrator and the consultant pharmacist immediately."

While completing an inspection of four Critical Incident Reports (CIR) that had been reported to the Director related to missing/unaccounted for controlled drugs, it was identified that three of the CIR reviewed related to a significant quantity of an identified missing and unaccounted controlled drug.
During an interview the DOC, they confirmed that a report to the Administrator had not been made when it had been identified that the home had experienced three incidents of irreconcilable differences related to the identified controlled drug and there was a pattern of irreconcilable differences with this controlled drug. During this interview the DOC acknowledged that the home did not have such a report.
During the same interview, the three incidents were discussed with the DOC and they acknowledged that there appeared to be an issue specifically related to missing and unaccounted for identified drug.

The directions in the above noted policy were reviewed by the DOC during the above noted interview and they confirmed that they had not complied with the directions in the policy when they did not submit a report to the Administrator when there had been irreconcilable differences with the controlled drug counts and did not notify the Administrator or the consultant pharmacist regarding a pattern of a missing and unaccounted identified controlled drug.

(PLEASE NOTE: The above noted no-compliance was related to safe storage of drugs was identified while inspecting Critical Incident Report (CIR) #027495-17 related to (CIR) #2784-000017-17 and #027495-17 related to CIR #2784-000005-18)

3. The licensee failed to ensure the policy "Bedside Medication Storage" was complied with.

This policy identified as policy #6.3., with a revised date of March 2018 and located in the Pharmacy Policy and Procedure Manual, directed:
"Medication shall be stored at the bedside only when authorized by the physician for a resident who has been assessed capable of self-administration".

a) While completing observations of in an identified resident room on an identified date, it was noted that there was a container sitting on the bedside table of

resident #025. The pharmacy label on the container identified the substance as a drug for resident #025.
A review of the physician's orders and resident #025's plan of care confirmed that the resident's physician had not ordered the resident to be able to self-administer this drug.

b) A second observation was made in the same room, on the same date when it was noted that there was a container sitting on the bedside table of resident #026. The pharmacy label on the container identified the substance as a drug for resident #026.
A review of the physician's order's and resident #026's plan of care confirmed that the resident's physician had not ordered the resident to be able to self-administer this drug.
On and identified date Personal Support Worker (PSW) #131, acknowledged the presence of the containers noted above on the bedside tables for resident #025 and resident #026.

The DOC and the Inspector reviewed the observations made in the identified room and the DOC confirmed that resident #025 and resident #026 were not ordered to self-administer the identified drugs and verified that staff had not complied with the licensee's policy when these drugs were left accessible to resident #025 and resident #026. (129)

4. The licensee failed to ensure the policy "Receiving Medications" was complied with.

This policy identified as policy #5.1.2., with a revised date of March 2018 and located in the Pharmacy Policy and Procedure Manual, directed:
"Authorized registered staff will ensure the safe receipt of medications from delivery personal, - for reorders, nursing shall compare the summary bag against the MAR/TAR to ensure all medications have been dispensed".

This policy was not complied with when it was identified that RPN #106 received reordered medications into the home for resident #021 and did not compare the medications received to the resident's MAR, which resulted in an identified medication not being available to be administered to the resident.

When reviewing a Medication Incident Report (MIR) provided by the home related to resident #021, the report and the ADOC confirmed that the resident did not

receive the identified drug which had been ordered by the resident's Physician for the resident to receive once a day.

A review of an identified date on resident #021's MAR indicated that RPN #145 had entered a "code 8" for the identified date which indicated the medication had not been administered.

During an interview with the DOC they provided a copy of the computerized "Drug Record Book *NEW*" for the drugs received over a three day identified period of time for resident #021. At that time they verified that according to the document, the above noted medication had not been received by the home between those dates. The DOC also reviewed the hard copy Drug Record book and confirmed that this medication had not been entered into the record as being received from the pharmacy.

During an interview with the DOC and RPN #106 they confirmed that they had received resident #021's medications into the home from the pharmacy on an identified date. When asked on two occasions, during this interview, to explain the process they follow when receiving medications into the home, they did not indicate that comparing the medications received with the resident's MAR was part of their practice and they were unsure how the medication had been missed.

The DOC confirmed that the above noted policy had not been complied with when RPN #106 had not compare medications being received into the home with resident #021's MAR, in order to ensure all medications had been received. (129)

D. The licensee failed to ensure policies included in the required Falls Prevention and Management program were complied with.

In accordance with O. Reg. 79/10, s. 48(1) 1 the licensee is required to have an interdisciplinary Fall Prevention and Management program and in accordance with O. Reg. 79/10, s. 30 (1) 1, the licensee is required to ensure that each of the required programs include policies, procedures and protocols.

The licensee's policy "Head Injury Routine", identified as NUR-V-183, last revised in June 2016 and included as part of the licensee's Falls Prevention and Management program, directed that "all residents who potentially may have sustained an injury to their head (abrasion, cut, swelling, bump or sudden onset of vomiting) following a fall or impact with an object, must have Head Injury Routine

(HIR) initiated" and it was presumed that a resident had suffered a potential head injury following a fall unless the fall was witnessed. This policy also directed that "registered staff were to complete the neurological-vital signs assessment every 15 minutes for the first hour, every hour for the next four hours, then every four hours for the next 19 hours to complete the first 24 hours and then every eight hours for the next 24 hours".

A review of CIS inspection log #017136-1 related to CIR #2784-000014-17, identified that on an identified date, resident #034 had an unwitnessed fall.

A review of the clinical record for resident #034 identified that registered staff did not initiate a HIR following this unwitnessed fall.

In an interview with RN #118, they confirmed that the HIR was not initiated as directed by the licensee's HIR policy for the unwitnessed fall and the licensee's policy was not complied with. (581)

(PLEASE NOTE: This non-compliance was issued as a result of CIS inspection: 017136-17 related to 2784-000014-17 which was conducted concurrently with the RQI) [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

WN #2: 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. (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. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 :

1. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

a) On an identified date in 2017, resident #043 was assessed by the physician. The assessment indicated the resident had an identified condition and no treatment needed at this stage.

The written plan of care revised 6 months later, did not identify the diagnosed condition.

The Director of Care (DOC) confirmed in an interview that the written plan of care did not identify the diagnosed condition and that it was their expectation that staff would have included this in the written plan of care.
The written plan of care was not based on the assessed needs of the resident. (130)

(PLEASE NOTE: This non-compliance was issued as a result of Complaint Inspection #003224-18, which was conducted concurrently with the Resident Quality Inspection (RQI).)

b) On an identified date resident #031 was observed in bed with their call bell not within their reach. The resident's plan of care provided specific directions to staff regarding the placement of the resident's call bell.

During an interview with the Assistant Director of Care (ADOC) on July 31, 2018, and review of the clinical record they verified that the specific placement of the resident's call bell should have been documented in the written plan of care.

The ADOC confirmed that the plan of care for resident #031 was not based on an assessment of the resident and the resident's needs and preferences. (581)

(PLEASE NOTE: This non-compliance was issued as a result of Complaint inspection: 011352-18 related to IL-57123-HA and 018154-18 related to IL-58170-HA, which was conducted concurrently with the RQI.) [s. 6. (2)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

a) The licensee failed to ensure the care set out in the plan of care for resident #004, related to supervision during a specific activity was provided as specified in the plan of care.

A review of the clinical record for resident #004 identified that they were at a risk for falls, they experienced a change in an identified care area, required assistance of one staff for identified activities and continuous supervision by staff for

identified activities. The resident's plan of care provided specific directions of the type and frequency of the assistance the resident required.

On an identified date resident #004 was observed by Inspector #683 over a two hour period of time. One hour an 35 minutes into the previously identified two hour period of time, Registered Practical Nurse (RPN) #108 asked Personal Support Worker (PSW)s #108, #109 and #110 if resident #004 was okay. PSW #109 briefly went into resident #004's room and identified to RPN #108 that the resident was okay. PSWs #108, #109 and #110 briefly stood outside of resident #004's room talking and then they left to provide care to other residents.

One hour and 45 minutes into the identified observation period, Inspector #683 went into resident #004's room and observed the resident in a particular position and did not observe any staff in the vicinity of the resident. Thirteen minutes later Inspector #683 identified to PSW #112 that the resident was in a particular position and there were no staff supervising the resident. PSW #112 identified that the resident was known to act independently and went to the resident's room to check on them.

In an interview with PSW #109, they identified that when they checked on the resident at the request of RPN #108, the resident had acted independently. Inspector #683 asked if the resident was supposed to be left without staff supervision and they identified that they were unsure, and that they would have to check their care plan.

In an interview with RPN #108 they confirmed that resident #004 was to be continually supervised at identified times and that PSWs #109, #110 and #111 should not have left the resident without supervision once they had discovered that the resident had acted independently.

PSWs #109, #110 and #110 did not ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan related to continuous supervision during identified activities. (683)

b) The licensee failed to ensure that care set out in the plan of care for resident #042, related to and identified care area was provided as specified in the plan of care.

A review of complaint log #018379-18, IL-58198-HA identified concerns related to

the care of an identified area for resident #042's.

A review of the clinical record for resident #042 identified that they had an identified diagnosis and a review of their written plan of care identified specific directions for the identified care area.

A review of the progress notes for resident #042 identified a note on an identified date, which identified that staff had not complied with the directions in the resident's plan of care related to the identified care area.

A review of the "Follow up Question Report" indicated that staff had not complied with resident #042's plan of care when providing the identified care to the resident on 6 days over a four month period of time.

In an interview with the Assistant Director of Care (ADOC), they acknowledged that as per electronic documentation, resident #042's identified care was not provided as directed in the residents plan of care. They also acknowledged the specific directions in resident #042's plan of care.

The home did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan, related to the identified care area. (683)

(Please note: This non-compliance was issued as a result of complaint inspection: 018379-18 related to IL-58198-HA, which was conducted concurrently with the RQI.)

c) The licensee failed to ensure that the care set out in the plan of care for resident #034, related to supervising the resident's activity, was provided as specified in the plan.

A review of Critical Incident Report (CIR) intake #017136-17, 2784-000014-17, submitted on an identified date in 2017, indicated that PSW #158 did not provide supervision to the resident while performing an activity and as a result the resident fell and sustained an injury.

On the above noted identified date, it was documented in the progress notes that resident #034 fell when they were not supervised during an activity and sustained an identified injury. A review of the written plan of care identified the resident that resident #034 was to be supervised while performing an identified activity due to a

risk of falling and this intervention had been in place for four months preceding the incident noted above.

It was confirmed in an interview with the DOC, that resident #034 was not supervised during an identified activity and that the care set out in the plan of care was not provided to resident #034 as specified in the plan. (581)

(Please note: This non-compliance was issued as a result of Critical Incident (CI): #017136-17 related to 2784-000014-17 which was conducted concurrently with the RQI.)

d) The licensee failed to ensure that the care set out in the plan of care for resident #043, related to laboratory specimen collection was provided as specified in the plan of care.

The plan of care for resident #043, stated that the resident used a medical device that was to be changed at a specified interval. The plan of care also directed registered staff to obtain a laboratory specimen with each device change.

A review of the plan of care, Treatment Administration Record (TAR) and laboratory reports indicated that laboratory specimens had not been obtained during the device changes on four identified dates in 2017.

The DOC confirmed in an interview in August 2018, that laboratory specimens had not been obtained during every device change and that the care was not provided in accordance with the plan of care. (130)

(PLEASE NOTE: This non-compliance was issued as a result of Complaint Inspection #003224-18, which was conducted concurrently with the RQI.)

e) The licensee failed to ensure that the care set out in the plan of care was provided to resident #053, related to collection of laboratory specimens.

The plan of care for resident #053, indicated that on an identified date in 2018, the physician wrote an order that directed staff to collect a specific laboratory specimen. The clinical record, specifically progress notes, reviewed two days later, indicated the identified laboratory specimen had not been obtained, as there were no progress notes to confirm the procedure had been performed and the

specimen obtained. On the same day the DOC stated, the laboratory requisition was still hanging on the wall awaiting processing. The DOC confirmed that it was the expectation that when the order was obtained, registered staff should have made an effort to obtain the identified laboratory specimen on each shift thereafter until the specimen was collected.

Care set out in the plan of care was not provided to resident #053 as specified in their plan of care. (130)

(PLEASE NOTE: this non-compliance was issued as a result of Complaint inspection: 018479-18, which was conducted concurrently with the RQI.)

f) The licensee failed to ensure that the care set out in the plan of care for resident #031, related to a medical device, use of an identified therapy and access to the nurse call system was provided as specified in the plan of care.

A review of Complaint intake #011352-18, IL-57123-HA and 018154-18, IL-58170-HA, submitted on an identified date in 2018, identified multiple care concerns which included but was not limited to the management of a medical device, staff not ensuring that an identified therapy was provided to the resident and the resident's access to the nurse call system.

i) On two identified dates in 2018, resident #031 was observed, by the Inspector, to be in an identified location several times throughout the day with the medical device in place. Review of the current written plan of care identified the resident was to use a specific type of medical device which was not the device in place when the above noted observations were made.

During an interview with ADOC, they stated that a specific type of medical device was to be used by the resident; however, after observing the resident in a particular location during the day, verified that the device in place was not the specific type of device the resident's plan of care required be used.

The DOC confirmed that the care set out in the plan of care was not provided to resident #031 as specified in the plan.

ii) On an identified date in 2018, resident #031 was observed by the Inspector, to be in a particular location while receiving a medical therapy. The resident's plan of

care directed that when the resident was in the identified location the medical therapy was to be set up as a portable therapy.
During an interview with PSW #134 on the same date, they stated that the medical therapy was only to be set up as portable when the resident was in a different location than the one identified above.
During an interview with the ADOC on the same date they stated the medical therapy provided to the resident was to be set up as a portable therapy when the resident was in the first identified location and that all PSW staff who provided care to the resident were to follow the directions in the resident's plan of care.

The DOC confirmed that the care set out in the plan of care was not provided to resident #031 as specified in the plan.

iii) During an interview with resident #031 on an identified date in 2018 it was observed that the resident was in bed and the call bell cord was wrapped around the call bell switch plate where the call bell was inserted into the wall and was not within reach for the resident. The resident verified they did not have their call bell all morning. The resident's plan of care provided specific directions that the call bell was to be clipped to the resident in a specific fashion to allow the resident to access the call bell.

During an interview with RPN #144 on the date identified above, they confirmed that the call bell was not clipped or within reach of the resident and stated that the call bell should have been clipped to the resident and within their reach.

RPN #144 confirmed that the care set out in the plan of care was not provided to resident #031 as specified in the plan.

The Administrator, ADOC and Inspector observed the resident in bed later that same day, it was noted that care had just been provided to the resident and the resident's call bell was observed on the floor. Interview with both the Administrator and the ADOC stated that the call bell should have been clipped to the resident as specifically directed in the plan of care after care was given and before the PSW staff left the room.

In an interview with PSW #137 on the same date, they stated that they had just provided care to the resident and confirmed that they did not clip the call bell on the resident before they left the room.

The Administrator and ADOC confirmed that the care set out in the plan of care was not provided to resident #031 as specified in the plan. (581)

(PLEASE NOTE: This non-compliance was issued as a result of Complaint inspection: #011352-18 related to IL-57123-HA and 018154-18 related to IL-58170-HA which was conducted concurrently with the RQI.) [s. 6. (7)]

3. The licensee failed to ensure that the provision of care set out in the plan of care was documented.

A review of Complaint log #011352-18, IL-57123-HA and 018154-18, IL-58170-HA, identified multiple care concerns.

Review of the reconciliation admission orders made on an identified date, indicated resident #031's physician ordered a component of a medical device use by the resident be changed at a specific interval. A review of the Treatment Administration Record (TAR) in April 2018, identified that the specified component was to be changed on a specific date. The TAR identified that on one designated day in April 2018 there was no documentation that the specified component had been changed and a review of the TARs for the months of May, June and July 2018, revealed that there was no documentation on these records to indicate the specified component had been changed at the specific interval as ordered.

In an interview with RPN #146 on an identified date, they confirmed they had not documented that they had changed the specified component on the TAR for an identified date in July 2018.

During an interview with RN #118, and review of the TARS it was identified there was an order to change the specified component on a specific date; however, it was discontinued on an identified dated when the medical device was no longer used for the resident. The following day the physician ordered the medical device was again to be used by the resident, however the order to change the specified component of the device weekly, had not been put back into the order by the registered staff and therefore did not transfer over to the TAR. RN #118 stated that there had been no documentation of when or if the specified component had been changed weekly in the TAR for three months.

RN #118 confirmed that registered staff failed to ensure the provision of the care set out in the plan of care was documented over the identified time period, as

stated above related to the requirement to change a specified component of a medical device used by resident #031. (581) [s. 6. (9) 1.]

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

A review of CIR intake #008973-17 submitted on an identified date indicated that improper treatment of a resident had resulted in harm or risk to a resident.

A review of the progress notes on an identified date in May 2017, indicated a referral was sent to Physiotherapist (PT) #2 to assess resident #036 related to an identified safety concern. The following day PT #2 assessed the resident and documented the outcome of that assessment in the computerized clinical record. The PT recommended a specific piece of equipment to be used by the resident during and identified activity and also made a recommendation about the level of support and supervision that staff should provided to the resident in order to ensure the resident's safety during the identified activity.

A review of the resident's plan of care at the time of the PT's recommendation did not indicate the specific recommendation made by the PT related both to the specific type of equipment that should be used or the level of support and supervision that staff should provide to the resident during the identified activity.

In an interview with the DOC, they verified the recommendations made by the PT, and after reviewing the plan of care, confirmed that the plan of care had not been reviewed and revised when the resident's care needs changed related to the specific equipment for the resident during the identified activity. (581)

(PLEASE NOTE: This non-compliance was issued as a result of CIS Inspection #008973-17, related to 2784-000013-17 which was conducted concurrently with the RQI.) [s. 6. (10) (b)]

5. The licensee failed to ensure that when the plan of care was being revised because the care set out in the plan had not been effective, that different approaches were considered in the revision of the plan.

Resident #042's written plan of care was revised when the care set out in the plan

of had not been effective in relation to an identified care concern. The DOC revised the written plan of care in July 2018, when a care decision was made.

In an interview in August 2018, with PT #1, they recommended an identified assessment be completed and made a recommendation following the completion of the assessment. When it was identified that the recommendation made by PT #1 was not acceptable, they confirmed they did not recommend an alternative approach to manage the identified care concern.

During an interview with the DOC they verified the identified concerns for resident #042. The DOC stated they did not consider other approaches on how to manage this care concern.

The DOC and PT #1 confirmed that when the plan of care was being revised, different approaches were not considered or implemented to manage the identified care concern. (581) [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 and ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of the safety risks with respect to the resident.

A review of complaints log #019798-18 and #018379-18 identified concerns related to resident #042 sustaining injuries during a specific activity.

Resident #042's written plan of care identified that they were a risk for impaired skin integrity. A review of the wound assessments for resident #042 identified that they sustained an injury on an identified date in October 2017 and April 2018. On an identified date in June 2018, the resident sustained an injury while staff were performing the specific identified activity with the resident.

Resident #042 was observed by Inspector #129 on an identified date and the observation provided some insight into how the injuries sustained by the resident could have happened based on the specific activity observed.

In an interview with PSW #100 by Inspector #581 on an identified date they identified specific situations that they felt could be causing the identified injury and also made recommendations to the Inspector about how the resident's personal equipment and activities could be altered to reduce the risk of the identified injuries to the resident.

A review of the clinical record for resident #042 did not identify any assessments related to the safety risks or the potential for the identified injury to resident #042.

In an interview with the DOC on an identified date, they acknowledged that injuries had occurred to resident #042 and they acknowledged to Inspector #581 that there were no assessments completed in relation to preventing these injuries to the resident.

The home did not ensure that the plan of care was based on an interdisciplinary assessment of the safety risks related to the potential for injury to resident #42.

(PLEASE NOTE: This non-compliance was issued as a result of complaints log #019798-18 and #018379-18, which were conducted concurrently with the RQI.)
[s. 26. (3) 19.]

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 and ensuring that the plan of care is based on, at a minimum, interdisciplinary assessment of safety risks, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

a) A review of Critical Incident System intake #029456-17 and the home's internal investigation notes identified that on an identified date in December 2017, resident #042 sustained an identified injury. The home's internal investigation identified that they believed PSW #150 transferred the resident in a manner not consistent with the resident's plan of care which resulted in the identified injury.

A review of the written plan of care and interview with the DOC, identified that at the time of the above noted incident, resident #042's plan of care provided specific directions for transferring the resident, that included the type of equipment to be used and the amount of assistance and supervision staff were to provided to resident #042 when assisting the resident to transfer.

In an interview with the DOC in August 2018, they confirmed that PSW #150 did not use safe transferring and positioning techniques when assisting resident #042

on the identified date. (683)

(PLEASE NOTE: This non-compliance was issued as a result of critical incident (CI) inspection: 029456-17, which was conducted concurrently with the RQI.)

b) A review of Complaint intake #011352-18 and IL-57123-HA submitted on an identified date, identified multiple care concerns which included an improper resident transfer.

On an identified date in August 2018, resident #031 was observed, by the Inspector, being transferred from bed by PSW #128 and PSW #129. During the transfer PSW #128 manoeuvred the resident's equipment in an identified manner.

During an interview with the DOC they stated that PSW staff were not to manoeuvre resident's equipment in the manner that was observed by the Inspector as that it was considered an unsafe transfer. The DOC provided the licensee's policy, on Use of Resident Chairs, Number: NUR-III-51 revised October 2017, which directed staff under transferring safety rules, never manoeuvre a resident's equipment in the manner that was observed by the Inspector.

The DOC confirmed that staff used unsafe transferring techniques when assisting resident #031 to transfer. (581)

c) A review of Complaint intake #018379-18 and IL-58198-HA submitted in July 2018, identified numerous care concerns that included but were not limited to a concern related to a specific are area for resident #042.

Review of the progress notes indicated that on an identified date the DOC had made a care provision decision based on the specific care area.

During an interview with the PT on an identified date, they stated they observed PSW not providing what they identified as safe care to resident #042 and provided details regarding what made the care they had observed unsafe.

During an interview with PSW #150 on an identified date, they verified that on an identified date they had provided care to the resident as was described above by the PT.

A review of an identified licensee's policy confirmed that staff were provided with specific directions about care to be provided related to the specific care area and this policy directed that staff were never to provide care as was observed being provided by the PT and verified as provided by PSW #150.

During an interview with the DOC in August 2018, stated they were aware that staff were providing care to resident #042 in the manner identified by the PT and verified by PSW# 150.

The DOC confirmed that PSW staff provided unsafe care to resident #042 related to a specific care area. (581)

(PLEASE NOTE: This non-compliance was issued as a result of Complaint Inspection #018379-18, IL-58198-HA, which was conducted concurrently with the RQI.) [s. 36.]

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 and ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that every resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) Resident #026 experienced altered skin integrity, for which the resident's physician had ordered the resident to receive a medication and registered staff did not reassess the resident's skin condition at least weekly.

During an interview with the ADOC on an identified date, they acknowledged that resident #026 was being treated for a change in their skin integrity and following a review of the Three Month Medication Review form it was confirmed that resident #026's physician had order that the skin treatment for area was to continue when they signed the medication review form on an identified date.
A review of resident #026's plan of care indicated that staff had identified a care focus related to "actual impairment of skin". Care interventions included in the plan of care related to the identified issue with skin integrity included the application of a medication and staff were to complete weekly skin assessments.
On an identified date in August 2018, the ADOC reviewed resident #026's clinical records and confirmed that weekly skin assessments related to the identified changes in the resident's skin integrity had not been completed in the month of

August 2018.

The DOC and clinical documentation confirmed that resident #026 demonstrated changes in their skin integrity and that the condition of the resident's skin was not reassessed at least weekly, as required. (129)

b) A "Complete Skin Assessment" was completed for resident #043 on an identified date in 2017, and indicated the resident had an alteration in their skin integrity to an identified area. There were no other assessments of this area until three months later.

A "Wound Assessment" completed on an identified date, indicated the resident had a change in their skin integrity to another identified area which required treatment; however, there were no further assessments of the affected area.

A "Wound Assessment" completed on an identified date, indicated the resident had another area of altered skin integrity; however, there were no further assessments of the affected area.

The DOC confirmed that registered staff did not consistently complete weekly wound assessments when it was clinically indicated. (130)

(PLEASE NOTE: This non-compliance was issued as a result of Complaint Inspection #003224-18, which was conducted concurrently with the RQI.) [s. 50. (2) (b) (iv)]

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 and ensuring that every resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of a missing or unaccounted for controlled substance no later than one business day after the occurrence.

a) The licensee informed the Director of the occurrence of missing/unaccounted for controlled substance that occurred on an identified date in May 2018, two business days following the occurrence when the home submitted a Critical Incident Report (CIR) on an identified date in May 2018.

A review of CIR #2784-000006-18 indicated that while the Assistant Director of Care (ADOC), the pharmacist and a pharmacist in training were completing the process of control substances destruction on an identified date in May 2018, documentation identified three tablets of an identified drug had been wasted by RPN #106 and RPN #144. When the pharmacist reviewed the plastic bag the medication had been placed in they identified that only one of the three tablets in the bag was the identified drug, the other two tablets were not the identified drug and they were identified as not being controlled substances.
During an interview, the DOC reviewed the CIR and confirmed that the home had

experienced an incident that involved missing/unaccounted for control substance that was not reported to the Director within one business day of the occurrence.

(PLEASE NOTE: The above noted no-compliance was related to reporting to the Director was identified while inspecting Critical Incident Inspection #009168-18 related to Critical Incident Report # 2784-000006-18.)

b) The licensee failed to inform the Director of an occurrence of missing/unaccounted for controlled substance that was identified by staff on an identified date in January 2018.

While completing a review of CIS #0274-000017-17 related to an incident of a missing/unaccounted for controlled substance that occurred on an identified date in November 2017, the Inspector observed an amendment that had been made to the report. The CIR indicated the amendment was made on an identified date in January 2018, and indicated that on an identified date in January 2018, it was discovered that seven vials of an identified drug had been tampered with.

During an interview, the DOC indicated that they believed there to be a link to the incident discovered on an identified date in January 2018 and the incident that occurred on an identified date in November 2017. They said the link they identified was that the incidents involved the same drug in both cases, they believed it was the same suspect and that was why they amended the CIS related to the November 2017 incident.
The DOC acknowledged that an incident of ten missing vials of a controlled substance that occurred in November 2017 and an incident where seven vials of a controlled substance were found to have been tampered with on an identified date in January 2018 were different incidents.
The DOC confirmed that the Director was not notified of an incident of missing or unaccounted for controlled substance when they identified on an identified date in January 2018 that seven vials of an identified drug had been tampered with and medication had been removed from those vials.

(PLEASE NOTE: The above noted no-compliance was related to reporting to the Director was identified while inspecting Critical Incident Inspection #009168-18 related to Critical Incident Report # 2784-000006-18.) [s. 107. (3) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the Director is informed of a missing or unaccounted for controlled substance no later than one business day after the occurrence, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

a) On two occasions while completing the Resident Quality Inspection it was noted that the medication cart was left unlocked and unattended in resident and public areas of the home.

i) On an identified dated and time, while making observations related to infection control, a medication cart was observed in the hallway outside an identified room on the second floor home area. It was noted at this time that the medication cart was unlocked and there were no registered staff in a position where they could see the medication cart. Observations of the unlocked medication cart continued for a period of time between five to seven minutes, no registered staff approached the medication cart during that period of time and it was also noted that one resident was wandering in the hallway at this time. RPN #117 exited the identified room and it was pointed out that the medication cart was unlocked.
RPN #117 confirmed that from their position inside the identified room they did not have visual contact with the unlocked medication cart.

ii) On an identified date and time observations were made in an identified location. It was observed that RPN #133 was administering medications to other residents with their back to the medication cart. At this time the Inspector observed the medication cart to be unlocked and unattended. The inspector moved to the front of the medication cart, could easily open all draws in the medication cart and noted that residents were moving past the medication cart and could have easily accessed medications. It was observed that there was a large structural column blocking the view to RPN #133 and that RPN #133 could not have seen someone standing at the medication cart because of this obstruction. When RPN #133 returned to the medication cart and noted the medication cart was unlocked they confirmed that they did not have visual contact with the unlocked medication cart.

Registered staff failed to ensure that drugs were secured in a medication cart that was locked when it was observed on two identified dates that RPN #117 and RPN # 133 had not locked the medication cart and they failed to maintain visual contact with the unlocked medication cart.

b) While making resident room observations on an identified date and time it was noted that specifically prepared medications had been left at the bedsides of two residents.

During an interview with the DOC, the inspectors findings related to the storage of the specifically prepared drugs at resident's bedsides were discussed and during this interview the DOC confirmed that the specifically prepared medications were to be secured in the locked cart when not in use.

Registered staff failed to ensure that specifically prepared medications were stored in a locked cart when not in use.

c) The licensee failed to ensure that drugs designated as control substances were kept in an area that was secure.

During an interview with the DOC and the ADOC related to CIS #0784-000017-17 they confirmed that while completing the controlled substance destruction process the ADOC and the Pharmacist noted that 10 vials of and identified drug were missing from the locked container that the medications were to be stored in.

The ADOC said they noted that at the time of the incident, the record sheet that identified the medication to be destroyed had been placed in the locked container, however, they were unable to find the medication in the locked container.

The ADOC confirmed they had interviewed three RPNs who had completed the count sheet and they all verified that they observed the medications going into the locked container with the record sheet.

The DOC confirmed that at the time of this incident the keys to the locked container where controlled drugs awaiting destruction were stored were kept in the DOC's office and other identified staff had access to the keys.

The DOC, ADOC and the CIS report submitted to the Director confirmed that 10 vials of a control substance had not been kept secure when the ADOC and the Pharmacist identified the above noted controlled substance had been removed from the locked container and other identified staff had access to the keys for this locked container.

(PLEASE NOTE: The above noted no-compliance was related to secure storage of drugs was identified while inspecting Critical Incident Report (CIR) #2784-000017-17 related to missing and unaccounted for controlled substances) [s. 129. (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 and ensuring that drugs are stored in an area or medication care that was secured and locked, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that medications were administered to resident #021 and resident #022 in accordance with the directions for use specified by their physicians.

a) An identified drug, was not administered to resident #021 in accordance with the directions specified by their physician.

A review of the clinical record and specifically, the "Best Possible Medication History/Reconciliation/Admission Orders" document, confirmed that the document was prepared on an identified date, and the physician signed the document to verify they had ordered the resident to be administered the identified drug daily. A Medication Incident Report (MIR) completed by the Assistant Director of Care (ADOC) indicated resident #021 had not received the above noted medication on an identified date in June 2018, because the medication was not available to be administered as the medication had not been dispensed/delivered to the home from the pharmacy.

During an interview, the DOC provided a copy of the computerized "Drug Record Book *NEW*" for the drugs received over a span of three days in June 2018, for resident #021 and they verified that according to the document the above noted medication was not received by the home between those dates. The DOC also reviewed the hard copy Drug Record book and confirmed that this medication was not entered into the record as being received from the pharmacy.
A review of the June 2018 Medication Administration Record (MAR) indicated staff had not administered the mediation on the identified date. The MAR indicated RPN #145 had entered a "code 8" on that date, which directed the reader to review a note made in the computerized clinical record about this medication. A review of the computerized clinical record confirmed that a note had not been written that identified the circumstances around this medication not being administered to resident #021 on the identified date.

During an interview with RPN #106, they confirmed that they received resident # 021's other medications into the home from the pharmacy, but when questioned about the process they followed, they did not indicate that they had checked the medications received against the resident's MAR to ensure that all the medications the resident had been ordered to receive had been sent by the pharmacy service provider.
The DOC reviewed the MIR, the MAR, communication from the pharmacy service provider, the computerized Drug Record Book *NEW*, the paper Drug Record Book and confirmed that resident #021 was not administered the identified drug on the identified date as was ordered by their physician.

b) An identified drug was not administered to resident #022 in accordance with the directions specified by their physician.

A review of the clinical record, specifically the "Physician's Orders", confirmed that the resident's physician had ordered the resident to receive the identified drug three times a day, every eight hours on an identified date in 2018. The three month medication review completed on identified dates in March and July 2018, confirmed that the resident's physician had ordered that the resident was to continue to receive the above noted drug throughout that period of time.
A review of the April 2018 MAR confirmed that RN #104 had made an "code 8" entry for the administration of this medication at an identified time on an identified date, which directed the reader to review a note made in the resident's electronic clinical record about this medication. A review of the computerized clinical record confirmed that a note had not been written that identified the circumstances

around this medication not being administered on the identified date.

RN #104 completed a written statement on the second page of the MIR where they verified that the above noted medication had not been administered to resident #022 at the identified time on the identified date.

Following a review of the above mentioned clinical records on an identified date in August 2018, the DOC and RN #104 confirmed that resident #022 had not received the identified drug at the identified time on the identified date, in accordance with the directions specified by the resident's physician. [s. 131. (2)]

2. The licensee failed to ensure that no resident administers a drug to themselves unless the administration has been approved by the prescriber in consultation with the resident.

On an identified date, RPN #132 left resident #024 with several medications to self-administer when the resident's physician had not approved that this resident could self-administer medications.

On the identified date and time, resident #024 was noted, by the Inspector, to be sitting in an identified location and it was noted at this time there was a medication cup sitting on the table with several medications in the cup for the resident to self-administer.
RPN #132 who was standing at the medication cart at an identified location was approached and asked if the resident had been approved to self-administer medications. RPN #132 confirmed that the resident had not been approved to self-administer medications and they also said that it was their practice to leave medications with resident #024. RPN #132 was then noted to approach resident #024 and observed the resident while they took the medications from the medication cup that had been placed on the table.
A review of the August 2018 Medication Administration Record (MAR) confirmed that resident #024's physician had ordered the resident to take eight medications on the identified date and time and there was no direction on the MAR that the resident was to self-administer these medications.
A review of the computerized physician's order tab in resident #024's clinical record confirmed that the resident's physician had not written an order to indicate that this resident was approved to self-administer medication.

RPN #132 confirmed that they had left resident #024 with several medications to

self-administer when the resident's physician had not given approval for this resident to self-administer medications. [s. 131. (5)]

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 and ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber and that no resident administers a drug to themselves unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #9: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was 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.

a) The licensee failed to ensure that the Director of Nursing and Personal Care and the pharmacy service provider were notified of a medication incident that involved resident #020.
Registered Nurse (RN) #104 completed a Medication Incident Report (MIR) that involved resident #020 and had occurred on an identified date in 2018. A review of the MIR indicated the resident had been ordered to receive an identified drug prior to admission to the home and when RPN #118 completed the medication reconciliation process upon the residents admission to the home, they had not included the information that resident #020 had been taking this medication prior to their admission to the home. RN #104, who completed the MIR identified the

incident as an error of omission and a transcription error. A review of the Medication Administration Record (MAR) for this period of time confirmed that the resident had not received the medication until four days after their admission to the home.

During an interview with RN #104, they confirmed that the information documented on the MIR was accurate and the pharmacy service provider had not been notified of this medication incident because it was their practice to only notify the pharmacy service provider if the medication incident was the result of a pharmacy error.

During an interview with the Director of Care (DOC), they confirmed that they had been not notified of the incident that involved resident #020 because they had designated the Assistant Director of Care (ADOC) to manage all medication incidents that occurred in the home and confirmed that the section on page two of the MIR identified as "Follow-up recommendations by DOC" had not been completed.

b) The licensee failed to ensure that the Director of Resident Care was notified of medication incident that involved resident #021.

RN #104 completed the first page of a MIR that involved resident #021 and had occurred on an identified date in 2018. A review of the MIR indicated that the identified drug had been ordered by resident #021's physician and that this incident was identified as an error of omission and a pharmacy dispensing error. The MIR indicated that the medication had not been dispensed from the pharmacy and the resident had not received the medication as a result. A review of the MAR confirmed that the above noted medication was not administered to the resident on the identified date.

During an interview, the DOC reviewed the MIR and confirmed they had not been notified of the incident that involved resident #021 because they had designated the Assistant Director of Care (ADOC) to manage all medication incidents that occurred in the home.

c) The licensee failed to ensure that the Director of Resident Care was notified of a medication incident that involved resident #022.

RN #104 completed a MIR that involved resident #022 and had occurred on an identified date. A view of the MIR indicated that the identified drug had been ordered by the resident #022's physician and this incident was identified as an error of omission. A review of the MAR indicated that the resident had not been administered the medication on an identified date and time. During an interview with the DOC, they confirmed that they had not been notified of the incident that

involved resident #022 because they had designated the Assistant Director of Care (ADOC) to manage all medication incidents that occurred in the home and confirmed that the section on page two of the MIR identified as "Follow-up recommendations by DOC" had not been completed. [s. 135. (1)]

2. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, reviewed, analyzed and corrective action was taken as necessary.

Staff did not ensure that a medication incident that involved resident #021 was reviewed, analyzed and corrective action was taken to prevent a recurrence.

RN #104 completed the first page of a MIR that involved resident #021 and had occurred on an identified date in 2018. A review of the MIR indicated that the identified drug had been ordered by resident #021's physician and that this incident was identified as an error of omission and a pharmacy dispensing error. The second page of the MIR that was to be completed by the nurse responsible for the incident, to include what they believed caused the incident, their recommendations to prevent a recurrence as well as follow-up recommendations from the DOC had not been completed.
During an interview, the DOC was asked to provide an explanation of how this medication incident occurred and because a review of the incident had not been documented, and there was no documentation to verify that the incident had been analyzed or what corrective action were to be taken, the DOC was unable to immediately provide the requested information.
During the above noted interview the DOC confirmed that the second page of the MIR had not been completed and there was no documentation to verify that the medication incident had been reviewed, analyzed or corrective action taken to prevent a recurrence. [s. 135. (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 and ensuring that every medication incident involving a resident and every adverse drug reaction is 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 and every medication incident involving a resident and every adverse drug reaction is documented and reviewed, analyzed and corrective action is taken as necessary, to be implemented voluntarily.

WN #10: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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 the Infection Prevention and Control program was evaluated and updated at least annually in accordance with evidenced based

practices and, if there are none, in accordance with prevailing practices.

During an interview with the DOC, they confirmed that they had not completed an annual review of the Infection Prevention and Control program for 2017. [s. 229. (2) (d)]

2. The licensee failed to ensure there was a designated staff member to co-ordinate the Infection Prevention and Control Program, who had education and experience in infection prevention and control practices, including, infectious diseases; cleaning and disinfection; data collection and trend analysis; reporting protocols; and outbreak management.

When the DOC was asked who was the staff person in the home who coordinated the Infection Prevention and Control Program, they responded by saying "either myself or the ADOC".
It was verified with the DOC that the home did not have a designated person who was responsible for the co-ordination of the Infection Prevention and Control program. [s. 229. (3)]

3. The licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control Program.

A) Staff in the home failed to participate in the implementation of the Infection Prevention and Control program when they did not store and label personal care items used by residents in a manner that prevented the possible spread of infection.

On an identified date, it was observed and documented in the computerized inspection program that there were soiled, unlabelled personal care items stored on the top of toilet tanks in three identified shared resident washrooms.
The following day, the Director of Care (DOC) and the Inspector completed a tour of two identified home areas and observed soiled, unlabelled personal care items stored on the top of toilet tanks in four identified resident washrooms. During the tour the DOC said that this was not an acceptable practice, the personal care items should have been labelled and stored in the provided storage area.
On the above noted date, the DOC confirmed that the storage of the identified personal care items used by residents was an infection control and prevention issue and that staff were not storing this equipment appropriately or as directed. (129)

b) Staff did not participate in the implementation of the licensee's Infection Prevention and Control Program when a component of an identified resident's medical device was observed to be stored properly.

On two identified dates in July and August 2018, the identified resident was observed in an identified location with the component of their medical device not stored properly.
During an interview with the ADOC and the Administrator on the identified date in July 2018, they observed the components of the resident's medical device not stored properly and the ADOC corrected the situation.
On an identified date in August 2018, during an interview with PSW #113, they observed the component of the identified resident's medical device not stored properly and verified who the component was expected to be stored.
In an interview on an identified date in August 2018, the DOC confirmed that the improper storage of the component of the resident's medical device would have been a violation of the licensee's Infection Prevention and Control Program.

The DOC confirmed that staff did not participate in the implementation of the licensee's Infection Prevention and Control program when it was observed on two identified dates in July and August 2018, that a component of the resident's medical device was stored inappropriately. (581)

c) The licensee failed to ensure that all staff participated in the Infection Prevention and Control program when it was identified that infection precaution signage and Personal Protective Equipment (PPE) had been removed when an identified resident continued treatment for transmittable infection.

On an identified date and time, it was brought to Inspector #129's attention, by staff #115, that an identified resident had been identified as having a transmittable infection and there was no signage to direct staff related to the precautions they should take when caring for the resident and there was no PPE available in the vicinity of the identified resident's room for use by staff. Staff #115 identified the specific transmittable infection.

On an identified date and time, observations were made in the vicinity around the identified resident's room. It was confirmed that there was no infection precaution signage posted and there was no PPE available in the vicinity of the room. While making these observations RPN #117 exited the identified resident's room and

verified that they had been told that signage and PPE had to be replaced.

A review of the identified resident's clinical record indicated, on an identified date in 2018, the resident returned to the home from hospital. The resident's plan of care included a copy of an e-mail to the Nurse Lead Outreach Team Member, which indicated the resident had been ordered to receive identified medication for an identified infection. Upon return from the hospital the DOC verified that infection prevention and control practices were implemented, which included the posting of infection precaution signage at the resident's room door and a caddy was placed outside the room which included PPE.

During an interview, the DOC confirmed the infection precaution signage and PPE were removed on an identified date when RN #119 administered the last dose of one of an identified medication the resident had been receiving and mistakenly thought this medication was administered for the treatment of the transmittable infection. The DOC confirmed that RN #119 then told the ADOC that the resident was no longer having identified symptoms of the transmittable infection and therefore they discontinued the infection prevention and control measures that were in place on the identified date, unaware that infection prevention and control measures were to be continued until the medication ordered by the physician to treat the transmittable infection had been completed as ordered by the resident's physician and the resident no longer demonstrated symptoms of the infection.

The DOC and clinical documentation confirmed that not all staff participated in the infection prevention and control program, when infection control measures, including the posting of signage to identify precautions staff and visitors were to take and PPE was not available for the use of staff and visitors when the identified resident continued to be treated for an infection which was identified as a transmittable infection. [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 and ensuring that the Infection Prevention and Control program is evaluated and updated at least annually in accordance with evidenced based practices and, if there are none, in accordance with prevailing practices, there is a designated staff member to co-ordinate the Infection Prevention and Control Program, who has education and experience in infection prevention and control practices, including, infectious diseases; cleaning and disinfection; data collection and trend analysis; reporting protocols; and outbreak management and all staff participate in the implementation of the Infection Prevention and Control Program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every residents' right to communicate in confidence, receive visitors of his or her own choice and consult in private without interference was fully respected and promoted.

According to the clinical record and in an interview with the DOC on an identified date in August 2018, it was identified that resident #053 had some degree of cognitive impairment following an assessment that had been completed on an identified date 2017.

On an identified date the licensee prohibited an identified visitor from entering the home.

In an interview with the Administrator, it was confirmed, that the above noted action had not been discussed with an identified visitor prior to the next visit and the Administrator confirmed that resident #053 was not given and opportunity to participate in the decision.

On an identified date in 2018, resident #053's Power of Attorney (POA) contacted the Administrator and requested the home reconsider allowing the identified visitor and resident #053 the opportunity to visit one another. The Administrator confirmed that they agreed to reconsider the visitation situation; however, they did not notify the identified visitor nor did they have a discussion about it with the resident or follow-up on the request.

Resident #053's right to communicate in confidence, receive visitors of his or her own choice and consult in private without interference was not fully respected and promoted over an identified period of time.

(PLEASE NOTE: this non-compliance was issued as a result of the following complaint #008123-18, which was conducted concurrently with the RQI. [s. 3. (1) 14.]

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of Regulation: 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A) On an identified date in August 2018, the DOC was unable to provide written documentation of the 2017 Skin and Wound Program Evaluation. The Doc confirmed the 2017 Program Evaluation was not completed for the Skin and Wound Program.

(PLEASE NOTE: This non-compliance was issued as a result of Complaint Inspection #003224-18, which was conducted concurrently with the RQI.) (130)

b) On an identified date in August 2018, the DOC was unable to provide written documentation of the Falls Prevention Program evaluation. The DOC confirmed in an interview that the Falls Prevention Program annual evaluation was not completed in 2017.

(Please Note: This non-compliance was issued as a result of CIS Inspection #017136-17 related to 2784-000014-17, which was conducted concurrently with the RQI.) (581) [s. 30. (1) 3.]

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

a) A review of CIS log #008973-17, 2784-000013-17 identified that on an identified date in 2017, PSW #155 reported alleged abuse when they witnessed rough handling of resident #036, from an identified person.

A review of the home's investigation notes identified that on the identified date, PSW #155 reported to the DOC they witnessed PSW #148 being rough with resident #036 while providing care, which resulted in the resident sustaining an injury.

Review of the progress notes on an identified date, did not identify that an assessment of the resident had been completed or documented.

During an interview with the DOC, they stated after they were notified of the incident on an identified date, they directed RPN #154 to assess the resident for any injuries or altered skin integrity. The DOC stated that RPN #154 verbally reported back that there was no evidence of further injury to the resident and that

the identified injury was healing and did not require and treatment. The DOC stated that it was the expectation that RPN #154 would have documented the assessment in electronic clinical record.

It was confirmed in an interview with the DOC, that on the identified date, RPN #154 failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. (581)

(PLEASE NOTE: This non-compliance was issued as a result of CIS inspection: 008973-17 related to 2784-000013-17 which was conducted concurrently with the RQI)

b) The plan of care for resident #043, stated that over an identified period of time the resident used an identified medical device that was to be changed at an identified interval.

A review of the Treatment Administration Record (TAR) indicated the medical device was not changed in January 2017, however, a laboratory report indicated a laboratory specimen had been obtained and analyzed on an identified date in January 2017. There was no progress note to indicate how and when this specimen was obtained.

The TAR indicated that the medical device had been changed on an identified date in February 2017, however, there was no progress note of the procedure performed nor the resident's response to the procedure. A laboratory report dated on an identified date in February 2017, indicated a laboratory specimen had been obtained and analyzed; however, there were no progress notes to indicate when and how this was done.

The TAR indicated the medical device was changed on an identified date in March 2017, however there was no laboratory report and no progress note to confirm that the medical device had been changed, what the resident's response was to the procedure and whether or not a laboratory specimen had been obtained.

The TAR indicated the medical device had been changed on an identified date in April 2017, however, there was no progress note of the procedure performed; the resident's response to the procedure, nor was there documentation to indicate

whether or not a laboratory specimen had been obtained.

The TAR indicated the medical device had been changed on an identified date in May 2017, however, there was no progress note of the procedure performed or the resident's response to the procedure. A laboratory report with an identified date, indicated a laboratory specimen had been obtained and analyzed; however, there were no progress note to indicate when and how this was done.

The TAR indicated the identified medical device was changed on an identified date in July 2017 and in August 2017, however, there was no progress note of the procedure performed; the resident's response to the procedure, nor was there documentation to indicate whether or not a laboratory specimen had been obtained.

A laboratory report found in the clinical record indicated a laboratory specimen had been obtained and analyzed on an identified date in September 2017; however, there were no progress notes to indicate when and how this was done.

The TAR indicated the medical device had been changed on an identified date in October 2017; however, there was no progress note of the procedure performed or the resident's response to the procedure.

A progress notes made on an identified date in November and December 2017, indicated the medical device had been changed; however, neither procedure had been signed for on the TAR.

It was confirmed in an interview with the DOC on an identified date, that on the identified dates, registered staff failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. (130)

(PLEASE NOTE: This non-compliance was issued as a result of Complaint Inspection #003224-18, which was conducted concurrently with the RQI.) [s. 30. (2)]

WN #13: 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 :

1. The licensee failed to ensure that a resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A review of complaint log #008677-18 identified concerns related to resident #004 not getting their baths/showers related to the home being short staffed.

A review of the written plan of care for resident #004 identified that they required assistance by one staff for bathing and identified that they preferred a bath and a shower. The written plan of care directed staff to see the bathing task for the specific choice/day. A review of the bathing task confirmed that staff were provided with specific directions about when and how the resident preferred to be bathed.

A review of the "Follow up Question Report", identified that the resident only had one shower during an identified week in April 2018, and one shower during an identified week in 2018. The resident missed their scheduled bath on and identified date in June 2018, and it was not made up. There was no documentation to support that the resident had a bath or shower the during an identified week in July 2018.

In an interview with the ADOC, they acknowledged that there was no documentation that the resident had a bath or shower on the identified dates.

The home did not ensure that resident #004 was not bathed, at a minimum, twice a week by the method of their choice.

(PLEASE NOTE: This non-compliance was issued as a result of complaint inspection: 008677-18 related to IL-56700-HA, which was conducted concurrently with the RQI.) [s. 33. (1)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a written response to concerns raised or recommendations made by Family Council were responded to within 10 days of receiving the advice.

Following completion of the Family Council Questionnaire by the license's Family Council representative and subsequent communication with the representative, it was identified that concerns and recommendations made at during Family Council meetings where not consistently responded to by the licensee.

A review of the licensee's Family Council binder, that included the Council's meeting minutes, indicated that during the meeting in January 2018, the Council raised concerns related to; the condition of the home's parking lot, lighting levels, laundry operation as well as concerns related to a Family Council communication board. It was also noted that during the Council's meeting in March 2018, the minutes reflected concerns raised related to; care, staff shortages, quality improvement issues and a security recommendation related to an incident of theft.

During an interview with staff #122, they explained that when the Council raised a concern or made a recommendation, staff #122 would write them down, send the concerns/recommendations to the appropriate manager, the manager would provide a response to staff #122 who would then print the manager's response, they would put the response in the Council's binder and forward the response by e-mail to selected members of the Council. At the time of the interview, staff #122 reviewed the Council's binder that was available for public viewing on the first floor home area and verified that there were no documents that represented a manager's concern/recommendation response to the above noted concerns/recommendations in the Council's binder.

Staff #122 reviewed their e-mail account on two identified dates in August 2018, and was unable to provide verification that the above noted concerns raised by Family Council during the January 2018 and March 2018, meetings were responded to in writing within 10 days of the Council raising the concerns/recommendations. [s. 60. (2)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Family Council, in acting on the results of the satisfaction survey.

During an interview on an identified date in August 2018, staff #122 confirmed that the minutes of the April 2017 Family Council meeting indicated that statistical results of the satisfaction survey had been provided to the Council and that a notation made in those meeting minutes indicated "more in-depth results with action plans will be posted for your review".

Staff #122 reviewed available information and confirmed that they were unable to verify that more in-depth results of the satisfaction survey identified in the April 2017 Family Council minutes had been provided to the Council. Staff #122 also verified that they were unable to provide evidence that action plans based on the statistical data results of the satisfaction survey had been shared with the Council or that the Council's advice had been sought related to any action plans the licensee had developed.

The Inspector reviewed Family Council meeting minutes for meetings held between in October 2017 and June 2018 as well as additional information included in the Family Council binder and confirmed that there was no documentation to verify that additional information had been provided to the Council during that period of time related to the results of the satisfaction survey and there was no indication that the Council's advice had been sought in acting on the results of the survey. [s. 85. (3)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which included the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

During an interview with the DOC, they confirmed that they had not completed an annual review of the effectiveness of the medication management system for the 2017 year. [s. 116. (1)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 228.
Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee failed to ensure that the improvements made to the quality of the accommodations, care, services and goods were communicated to the Family Council of the home on an ongoing basis.

During an interview on an identified date in August 2018, staff #122 confirmed that quality indicator statistical data had been provided to Family Council at the April 2017 Council meeting and this had been documented in the minutes of that meeting.
Staff #122 reviewed information available to them and confirmed, that they were unable to provide evidence that quality improvements made based on the statistical data provided to the Council at the April 2017 Council meeting had been communicated to the Family Council.
The Inspector reviewed Family Council meeting minutes for meetings held between October 2017, and June 2018, as well as additional information included in the Family Council binder and confirmed that there was no documentation to verify that information had been provided to the Council during that period of time related to the quality improvements made by the licensee based on the statistical quality data information provided to the Council during the April 2017 meeting. [s. 228. 3.]

Issued on this 17th day of December, 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by PHYLLIS HILTZ-BONTJE (129) - (A1)
Inspection No. / No de l'inspection :	2018_587129_0009 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	018704-18 (A1)
Type of Inspection / Genre d'inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 17, 2018(A1)
Licensee / Titulaire de permis :	Barton Retirement Inc. 1430 Upper Wellington Street, HAMILTON, ON, L9A-5H3
LTC Home / Foyer de SLD :	The Wellington Nursing Home 1430 Upper Wellington Street, HAMILTON, ON, L9A-5H3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lisa Brentnall

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Barton Retirement Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

(A1)
The licensee must be compliant with s. 8(1) (b) of the LTCHA.
- "Quarterly Nutritional Assessment", (NFS-11-07)
- "Destruction and Disposal of Narcotics and Controlled Substances", (Pharmacy Policy 3.3.19.)
- "Narcotic and Controlled Medications", (Pharmacy Policy 6.2.)
- "Bedside Medication Storage", (Pharmacy Policy 6.3.)
- "Receiving Medications", (Pharmacy Policy 5.1.2.)

The plan is to include, but not limited to:

1. A schedule for the implementation of face to face training for staff who are responsible to comply with the directions included in the above noted policies and procedures. The licensee is to maintain training records for the face to face training that includes; training content and staff attendance records.

2. The development of audit tools and a schedule for implementation of those tools to ensure that:
-residents who use indwelling catheters receive care constant with the above noted policies,
-resident's personal bed pans and urinals are stored in a manner consistent

with the above noted policy,
-Head Injury Routine is implemented for each resident who has fallen in accordance with the above noted policy,
-Quarterly nutritional assessments are completed in accordance with the above noted policy,
The licensee shall prepare, submit and implement a plan to ensure that the following policies and procedures are complied with:
- "Insertion, Removal and Maintenance of an Indwelling Catheter", (NUR-V-75)
- "Urine Specimen – Midstream", (NUR-254)
- "Urine Dipstick Procedure", (NUY-V-252)
- "Bed Pan and Urinal Storage", (NUR-VI-43)
- "Head Injury Routine", (NUR-V-183)

-Management of Narcotics and Controlled Medications, including storage, wasting and destruction is carried out in accordance with the above noted policies,
-Prescription treatment creams are stored in accordance with the above noted policy,
-Only residents who have been approved by their physician to self-administer medications are left with medications to self-administer, in accordance with the above noted policy,
-The process for receiving medications into the home from the pharmacy provider is carried out in a manner consistent with the above noted policy.

A record of the above noted audit schedules, tools, outcomes and any recommendations implemented following the audits are to be maintained by the home.

Please submit the written plan for achieving compliance for inspection 2018_587129_0009 to Phyllis Hiltz-Bontje, LTC Homes Inspector, MOHLTC, by email to HamiltonSAO.moh@ontario.ca by November 22, 2018.

Grounds / Motifs :

1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to

ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

A) The licensee failed to ensure that the policies included in the Medication Management System were complied with.

In accordance with O. Reg. 79/10, s. 114 (2) the licensee is to ensure 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.

i) The licensee failed to ensure the policy "Destruction and Disposal of Narcotic and Controlled Substances" was complied with.

While completing Critical Incident System (CIS) #0091680-18 inspection, related to Critical Incident Report (CIR) #2784-0000006-18, which had been reported to the Director as an incident of missing/unaccounted for controlled substances, the Director of Care (DOC) was asked to provide the licensee's policy that identified the process to be followed by registered staff when disposing of a narcotic or controlled substance. In response the DOC provided the above title policy which was identified as Policy 3.3.19 with a revised date of March 2018, located in the Pharmacy Policy and Procedure Manual and verified that the above noted policy was the policy staff were expected to follow when dealing with the destruction and disposal of narcotic and controlled substances.

This policy directed:
"Loose narcotic medications such as pills that a resident has refused, is not able to swallow, or are not administered due to hospitalization etc., must be wasted by two nurses to complete the waste process.
The waste process includes:
-The waste must be documented on the Combined Monitoring Medication Record with Shift Count under the section "wasted".
-A photocopy of the individual count sheet must be made, and placed along with the medication being wasted into a zip lock bag provided in the medication room.
-The sealed zip lock bag (containing the copied count sheet and the medication) is placed in the narcotic destruction box located in the medication room on the first floor."

The above noted policy was not complied with when RPN #144 and RPN #106 did not follow the above noted directions when they wasted three tablets of an identified drug on May 2, 2018.
During an interview on August 24, 2018, with the Assistant Director of Care (ADOC), they identified that while completing a control substance count, it was identified that RPN #144 and RPN #106 wasted three tablets of the identified drug that were no longer required by placing them in an identified container. This incident had been discovered when the ADOC and the Pharmacist completed the process for controlled drug destruction.

The ADOC confirmed that they immediately launched an investigation when they found the controlled substance in the identified container and during their investigation into this incident they interviewed RPN #106 who confirmed that at the time of the incident they consulted with RPN #144 and the identified drugs were put in the identified container.

The ADOC verified that when they interviewed RPN #144 following the incident, RPN #144 confirmed that wasting controlled substances by putting them into the identified container was a practice in the home.

The ADOC and a CIR submitted to the Director confirmed that the licensee's policy "Destruction and Disposal of Narcotic and Controlled Substances" had not been complied with.

ii) The licensee failed to ensure the policy "Narcotic and Controlled Medication" was complied with.

While completing CIS #027495-17 inspection, related to CIR #0784-000017-17, which had been reported to the Director as an incident of missing/unaccounted for controlled substances, the DOC was asked to provide the licensee's policy that identified the directions for storing medications that had been identified as controlled substances. In response the DOC provided the above title policy which was identified as policy 6.2., with a revised date of March 2018 and was located in the Pharmacy Policy and Procedure Manual. The DOC verified that the above noted policy was the policy staff are expected to follow for the storage of controlled substances.

This policy directed:
"Narcotic and controlled substances that have been discontinued or for a resident that has deceased are stored in a designated locked area for such storage, along with the Resident Controlled Substance Count Sheet. Only the DOC (designate) and the Pharmacist shall have a key to this storage area."

During an interview with the Director of Care (DOC) and the ADOC, they confirmed that on an identified date in 2017, it was identified that 10 vials of a drug identified as a controlled substance had been removed from the designated locked area that had been designated to store these drugs.
During the above noted interview the DOC confirmed that they had not complied with the policy that directed only the DOC (delegate) and the Pharmacist would have keys and access to the designated storage area when prior to the above noted incident the keys to this designated area were kept in the DOC's office and other identified staff had access to the keys to unlock the designated storage area.

This policy directed:
"Any discrepancy in narcotic and controlled drug count is reported immediately to the DOC. The DOC shall attempt to reconcile all reported discrepancies. The DOC shall submit a report to the administrator for irreconcilable differences"
"If a major discrepancy or a pattern of discrepancies occurs, the DOC shall notify the administrator and the consultant pharmacist immediately."

While completing an inspection of four Critical Incident Reports (CIR) that had been reported to the Director related to missing/unaccounted for controlled drugs, it was identified that three of the CIR reviewed related to a significant quantity of missing and unaccounted controlled drug related to an identified drug.
During an interview the DOC, they confirmed that a report to the Administrator had not been made when it had been identified that the home had experienced three incidents of irreconcilable differences related to the identified controlled drug and there was a pattern of irreconcilable differences with this specific controlled drug.
During this interview the DOC acknowledged that the home did not have such a report.
During the same interview, the three incidents were discussed with the DOC and they acknowledged that there appeared to be a pattern specifically related the identified drug being missing and unaccounted for.

The directions in the above noted policy were reviewed by the DOC during the above noted interview and they confirmed that they had not complied with the directions in the policy when they did not submit a report to the Administrator that there had been irreconcilable differences with the controlled drug counts and did not notify the Administrator or the consultant pharmacist regarding there being a pattern of missing and unaccounted controlled drugs related to the identified drug.

iii) The licensee failed to ensure the policy "Bedside Medication Storage" was complied with.

This policy identified as policy #6.3., with a revised date of March 2018 and located in the Pharmacy Policy and Procedure Manual, directed:
"Medication shall be stored at the bedside only when authorized by the physician for a resident who has been assessed capable of self-administration".

a) While completing observations in an identified resident room on an identified date, it was noted that there was a container sitting on the bedside table of resident #025. The pharmacy label on the container identified the substance as a drug for resident #025.
A review of the physician's orders and resident #025's plan of care confirmed that the resident's physician had not ordered the resident to be able to self-administer this drug.

b) A second observation was made in the same room, on the same date when it was noted that there was a container sitting on the bedside table of resident #026. The pharmacy label on the container identified the substance as a drug for resident #026.
A review of the physician's order's and resident #026's plan of care confirmed that the resident's physician had not ordered the resident to be able to self-administer this drug.
On an identified date, Personal Support Worker (PSW) #131, acknowledged the presence of the containers noted above on the bedside tables for resident #025 and resident #026.

On August 13, 2018, the DOC and the Inspector reviewed the observations made in the identified room and the DOC confirmed that resident #025 and resident #026 were not ordered to self-administer the identified drug and verified that staff had not complied with the licensee's policy when these drugs were left accessible to resident

#025 and resident #026.

iv) The licensee failed to ensure the policy "Receiving Medications" was complied with.

This policy identified as policy #5.1.2., with a revised date of March 2018 and located in the Pharmacy Policy and Procedure Manual, directed:
"Authorized registered staff will ensure the safe receipt of medications from delivery personal for reorders, nursing shall compare the summary bag against the MAR/TAR to ensure all medications have been dispensed".

This policy was not complied with when it was identified that RPN #106 received reordered medications into the home for resident #021 and did not compare the medications received to the resident's Medication Administration Record (MAR), which resulted in an identified medication not being available to be administered to the resident.

When reviewing a Medication Incident Report (MIR) provided by the home related to resident #021, the report and the ADOC confirmed that the resident did not receive the identified drug which had been ordered by the resident's Physician for the resident to receive once a day.

A review of resident #021's June 2018 MAR indicated that RPN #145 had entered a "code 8" for an identified date, which indicated the medication had not been administered.

During an interview, the DOC provided a copy of the computerized "Drug Record Book *NEW*" for the drugs received for an identified three day period of time in June 2018, for resident #021. At that time they verified that according to the document, the above noted medication had not received by the home between those dates. The DOC also reviewed the hard copy Drug Record book and confirmed that this medication had not been entered into the record as being received from the pharmacy.

During an interview with the DOC and RPN #106, RPN #106 confirmed that they had received resident #021's medications into the home from the pharmacy and the identified date. When asked on two occasions, during this interview, to explain the

process they follow when receiving medications into the home, they did not indicate that comparing the medications received with the resident's MAR was part of their practice.

The DOC confirmed that the above noted policy had not been complied with when RPN #106 had not compared medications being received into the home with resident #021's MAR, in order to ensure all medications had been received.

B) the licensee failed to ensure that the policies included in the Nutrition Care and Dietary Service program where complied with.

In accordance with applicable requirements under the Act and in accordance with s. 11. (1), that required a long term care home to ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

The licensee's policy "Quarterly Nutritional Review Assessment", identified as NFS-III-07 with a revised date of January 2002, located in the Nutrition and Food Service Manual, stated that all residents would have a quarterly nutritional assessment and the results of the quarterly nutritional review would be communicated to all members of the Health Care Team.

According to the plan of care, resident #053 was assessed at nutritional risk. A quarterly review assessment completed by the Food Service Supervisor (FSS) on an identified date in 2017, stated the resident' intake was below their recommended daily intake. The Registered Dietitian (RD) confirmed in an interview on and identified date, that the results of this quarterly assessment were not communicated to them. The coding completed during the following quarterly review time period, triggered a Resident Assessment Protocol (RAP) for an identified condition. The RAP stated the resident consumed less than their daily recommended intake. The remainder of the nutritional RAP summary was incomplete. There were no referrals made to the RD to assess potential identified condition, despite the condition being trigger and there were no objectives specified when the resident's intake fell below the recommended daily intake. The RD confirmed in an interview on an identified date, that a nutritional quarterly assessment was not completed in February 2018 and that they were not informed when the resident's intake was below their recommended daily fluid intake in November 2017 and February 2018.

The licensee's policy "Quarterly Nutritional Review Assessment, NFS-III-07, revised on January 2002, was not complied with.

C) The licensee failed to ensure that the policies included in the Nursing Services program were complied with.

In accordance with applicable requirements under the Act and in accordance with s. 8. (1) (a), that required a long term care home to ensure that there was an organized program of nursing services for the home to meet the assessed needs of the resident.

i) The licensee's policy identified as NUR-V-75, revised on March 2018, provided directions for registered staff, which included instruction to document the procedure in the resident's electronic record .

a) The plan of care for resident #043, stated that for a two year period of time the resident used the identified medical device that was to be changed at an identified interval. The Treatment Administration Record (TAR) was reviewed and initialled by registered staff to indicate the medical device had been changed on an identified date in April, May, July, August and October 2017.
A review of the electronic clinical notes confirmed that the procedure for changing the medical device had not been documented in the electronic record on the identified date in April, May, July, August and October 2017, as required by policy.

It was confirmed in an interview with the DOC, that registered staff failed to document the medical device changes on the identified dates and that the above noted licensee's policy had not been complied with.

B) On an identified date resident #031 was admitted to the home with the use of a medical device and review of the orders directed registered staff to change the medical device at an identified interval. The (TAR) was reviewed and identified that the medical device had been changed on an identified date.
A review of the progress notes documented in the electronic clinical record on that date, identified there were no notes recorded describing the procedure that was done, the assessment of the resident nor the resident's response to the procedure.

During an interview with the DOC, it was confirmed on the identified date registered staff failed to ensure that the licensee's policy was complied with.

Ii) The licensee's policy NUR-V-254, revised February 2001, directed staff to chart the procedure on the nursing record; indicate colour, odour, quantity and pertinent observations related to the collection of an identified laboratory specimen. Policy NUR-V-252, revised February 2018, stated all identified laboratory specimens that are collected would be tested first onsite.

The clinical record of resident #053 contained a progress note documented on an identified date and time by registered staff #117, which stated an identified laboratory specimen was obtained. The clinical note did not include the procedure nor did it specify whether or not the specimen collected was tested first.

Registered staff #117 confirmed in an interview, that they had not document the procedure for obtaining the identified specimen and that they had not perform the test before sending the specimen to the laboratory.

The licensee's policy NUR-V-254 and NUR-V-252 were not complied with.

iii) The licensee failed to ensure that policy NUR-VI-43, dated March 2005 and located in the Nursing Policy and Procedure Manual was complied with.

The above noted policy directed the following:
-Each resident's identified personal care items must be labelled with the individual resident's name,
-Each resident's identified personal care items are emptied, rinsed and cleaned after each use,
-Individual identified personal care items that are used by a resident, are kept in an identified location, when not in use.

On July 26, 2018, while completing stage 1 of the Resident Quality Inspection (RQI), observations were made in resident's rooms by Inspector 129. It was noted by the Inspector that there were soiled, unlabelled identified personal care items stored on the backs of toilet tanks in three identified resident rooms.

The above noted observations were shared with the DOC on July 27, 2018. On that

date the Inspector and the DOC toured two resident home areas where it was observed that soiled, unlabelled identified personal care items where noted to be stored on the tops of toilet tanks in rooms four identified rooms.

The DOC confirmed that staff had not complied with the licensee's policy noted above when they did not label, rinse and clean or store resident's personal care items in accordance with the above noted policy.

D) The licensee failed to ensure that the policies included in the Fall Prevention and Management program were complied with.

In accordance with O. Reg. 79/10, s. 30 (1), the long term care home was required to ensure that the following is complied with for each of the organized programs required under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of the Regulation: There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes including protocols for the referral of residents to specialized resources where required. In accordance with O. Reg. 79/10, r.48 (1) 1, the home was required to have a Falls Prevention and Management Program.

Specifically staff did not comply with the licensee's policy, NUR-V-183, last revised, June 2016 regarding Head Injury Routine (HIR) policy, which was part of the licensee's falls prevention and management program when they did not complete a HIR after resident #034 sustained an unwitnessed fall on an identified date in 2017

The policy identified that, "all residents who potentially may have sustained an injury to their head (abrasion, cut, swelling, bump or sudden onset of vomiting) following a fall or impact with an object, must have head injury routine initiated" and it was presumed that a resident had suffered a potential head injury following a fall unless the fall was witnessed. The HIR directed registered staff that the neurological-vital signs assessment was to be completed every 15 minutes for the first hour, every hour for the next four hours, then every four hours for the next 19 hours to complete the first 24 hours and then every eight hours for the next 24 hours.

A review of CI log #017136-17, 2784-000014-17, identified that on an identified date in 2017, resident #034 had an unwitnessed fall.

A review of the clinical record for resident #034 identified that registered staff did not initiate a HIR post the unwitnessed fall identified above.

In an interview with RN #118, they confirmed that the HIR was not initiated as directed by the licensee's HIR policy for the unwitnessed fall on the above noted date and the licensee's policy was not complied with.

This non-compliance was issued as a result of CIS inspection: 017136-17 related to 2784-000014-17 which was conducted concurrently with the RQI

2. The severity of this issue was determined to be a level 2 as there was a potential for actual harm to the residents. The scope of the issue was a level 2 as there was a pattern identified related to non-compliance with the licensee's policies. The home had a level 3 history of one or more related non-compliance within the last 36 months with this section of the Ontario Regulation that included:
-Voluntary Plan of Corrective Action (VPC) issued August 22, 2016, (2016_341583_0012)
-Voluntary Plan of Corrective Action (VPC issued June 1, 2017, (017_577611_0010)

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 17th day of December, 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by PHYLLIS HILTZ-BONTJE (129) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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