Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 12, 2017	2017_642606_0012	017421-17	Resident Quality Inspection

Licensee/Titulaire de permis

McKenzie Health
10 TRENCH STREET RICHMOND HILL ON L4C 4Z3

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

Mackenzie Health Long Term Care Facility
10 TRENCH STREET RICHMOND HILL ON L4C 4Z3

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

JANET GROUX (606), NITAL SHETH (500), ROMELA VILLASPIR (653), SARAN DANIEL-DODD (116), SIMAR KAUR (654)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 2, 3, 4, 8, 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 28, 29, and 30, 2017.

The following intakes were inspected concurrently during the RQI.
Critical incidents (CI):
Log # 001496-17, and #014758-17 related to allegation of staff to resident abuse.
Log # 030475-16 and # 015024-17 related to residents falls resulting in injuries.
Complaints (CO) intakes:

**Log # 012643-15 related to plan of care and falls prevention and management;
Log # 034797-16 related to an allegation of abuse.
Log #001324-17 related to duty to protect and medication administration.
Log # 014532-17 related to medication administration, duty to protect from abuse and neglect, dietary services and hydration, transferring and positioning, skin and wound management, continence care and bowel management.
Log # 016525-17 related to therapy services, plan of care, dealing with complaints, food production, medication administration, infection control and prevention program, menu planning, duty to protect from abuse and neglect, foot and nail care, transferring and positioning, continence care and bowel management, skin and wound care management, and Falls prevention and management.**

During the course of the inspection, the inspector(s) spoke with the Administrator, Administrative Director of Care (A)DOC, Clinical Director of Care (C)DOC, Infection Prevention and Control (IPAC)/Continuous Quality Improvement (CQI) Manager, Physiotherapist (PT), Chiropodist, Admissions Coordinator, Resident Assessment Instrument Minimum Data Set Coordinator (RAI MDS), Physicians, Orthopaedic Surgeon, Dietitian, Dietary Manager (DM), Social Worker (SW), Coordinator of Environmental Services (Housekeeping and Laundry), Director Facility Services (Maintenance), Plant Operations Security and Site Prevention Officer, Director of Care (DOC) Clerk, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping, Humber College Student, Private Duty Caregivers (PDC), Food Service Attendant (FSA), Residents' Council (RC) President, Family Council (FC) Member, Substitute Decision Makers (SDM), and Residents.

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff to resident interactions, interviewed the Residents' Council (RC) President, interviewed a member of the Family Council (FC), reviewed RC and FC meeting minutes, reviewed clinical health records, staffing schedules/assignments, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

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

Specifically failed to comply with the following:

s. 6. (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. (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 has failed to ensure that the care set out in the plan of care had been provided to the resident as specified in the plan.

Review of a CIS on an identified date reported an allegation of staff to resident abuse.

Review of the CIS revealed that on an identified date and time, resident #006 reported to the Administrative Director of Care (A)DOC that Personal Support Worker (PSW) #129 was abusive towards him/her during care. The resident stated that the PSW had provided care in an identified manner despite of the resident's ability to follow instructions and assist with the care. The PSW refused to stop when the resident told him/her to stop because he/she was hurting the resident.

Review of resident #006's written plan of care on an identified date directed staff to provide an identified care with two staff during the night.

Interview with PSW #129 stated he/she provided the care by himself/herself, and that he/she did not follow resident #006's written plan of care. The PSW further indicated that there was no other staff available to assist him/her at the time, and that resident #006 agreed for the PSW to provide the care by himself/herself.

Review of the Administrator's letter on an identified date addressed to PSW #129 indicated the home's investigation revealed he/she did not follow resident #006's plan of care at the time of the incident, and as a result the interaction between PSW #129 and resident #006 deteriorated.

Interview with the Administrator acknowledged that PSW #129 did not follow resident #006's plan of care, and that the home's expectation was for staff to follow the plan of care when providing care to the residents. [s. 6. (7)]

2. Review of a CIS reported an allegation of staff to resident abuse.

Review of resident #023's progress notes on an identified date, indicated the resident reported to Registered Nurse (RN) #100 that on an identified time PSW #168 had provided an identified care to resident #023. The progress notes indicated the resident told PSW #168 that he/she had wanted the PSW to replace an identified item on his/her bed as it was in an identified state. Resident #023 indicated PSW #168 then became upset after he/she requested for an identified item on his/her bed to be replaced and told the resident that he/she had already replaced the identified item on bed and that the identified item on the bed did not require an identified care assistance. Further review indicated resident #023 alleged PSW #168 then directed the resident in an identified manner to prove to the resident that the identified care item on his/her bed did not require to be replaced. Further review of the progress notes indicated that resident #023 indicated that when PSW #168 directed him/her in an identified manner to try and prove to him/her that the identified item on the bed did not require an assistance with care, the resident indicated he/she felt pain to an identified are of his/her body and told PSW #168 that he/she was in pain. Resident #023 indicated that PSW #168 then apologized to him/her and asked the resident if he/she wanted a pain medication for the resident's pain. Resident #023 indicated the PSW then left the room. The progress notes indicated that resident #023 indicated that he/she reported the incident to the night shift charge nurse RN #165.

Review of resident #023's written care plan on an identified date, indicated resident #023 required assistance for an identified care related to several health conditions. The written care plan directed the staff not to provide care in an identified manner and to ensure that an identified part of the resident's body was never to be moved in an identified position as doing this may cause an identified skin integrity impairment and pain to an identified area of the resident's body.

Interview with resident #023 indicated that he/she recalled the incident with PSW #168 and indicated that he/she had requested for the PSW to replace an identified item on his/her bed and indicated PSW #168 had handled him/her in an identified manner when the PSW had attempted to show the resident that the identified item on the bed did not

require to be replaced. Resident #023 stated that PSW #168 provided an identified response to him/her and did not replace the identified item on his/her bed and indicated PSW #168 then walked out of the room.

Interview with PSW #168 indicated that during the identified time and date of the incident, he/she had provided an identified care to resident #023 and had completed the care. The PSW indicated that resident #023 told him/her that the resident requested for the PSW to replace an identified item on his/her bed and that the PSW indicated he/she had already replaced the identified item and that it did not require to be replaced. The PSW indicated he/she then attempted to prove to resident #023 to confirm that the identified item on the bed did not require to be replaced. The PSW #168 indicated he/she did not touch the resident's in an identified manner that caused pain to identified areas of the resident's body.

Interview with RN #100 indicated resident #023 reported to him/her on an identified date and time, that PSW #168 had provided an identified care to the resident. RN #100 indicated that the resident indicated that he/she told the PSW that he/she wanted an identified item on his/her bed to be replaced because the resident indicated the identified item on his/her bed was in an identified state. The RN indicated resident #023 told him/her that PSW #168 then in an identified manner directed the resident using an identified body part of resident #023 to confirm on his/her own that the identified care item was not in an identified state and did not require to be replaced. RN #100 indicated that resident #023 has an identified medical condition and experiences pain to an identified area of his/her body and indicated staff have been directed to be careful with the resident’s identified body part during care.

Interview with RN #165 indicated resident #023 informed him/her on an identified date and time, during a medication pass that PSW #168 had provided an identified care to him/her and that he/she wanted the PSW to replace an identified item on his/her bed as the item was in an identified state. The RN indicated that resident #023 told her that PSW #168 handled an identified body part of the resident in an identified manner to prove to the resident that the identified item on the bed did not need to be replaced. The RN further indicated that staff know that resident #023 has an identified pain to an identified part of his/her body due to an identified medical condition and the identified area should not be touched during care. RN #165 indicated resident #023's plan of care directed staff not to touch an identified area of the resident's body in an identified manner and directed staff to have two staff to provide care.

Interview with the (A)DOC indicated resident #023's plan of care indicated the resident has an identified medical condition and has pain in an identified area of his/her body and require staff to be careful with the resident's identified body part during care. The (A)DOC indicated PSW #023 did not follow resident #023's plan of care. [s. 6. (7)]

3. Review of a complaint submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, reported improper care and staff abuse regarding resident #022.

Interview with resident #022's Substitute Decision Maker (SDM) indicated that resident #022 was admitted to the home on an identified date, during an identified time. The SDM indicated that resident #022 was provided an identified care at the hospital prior to being admitted to the home. The SDM indicated that after resident #022 was admitted the SDM indicated that he/she then left the home and returned later on that day. The SDM indicated that when he/she arrived he/she observed resident #022 and indicated he/she identified resident #022 in an identified state and indicated the home had not provided the resident an identified care. The SDM indicated the resident did not receive an identified care because he/she also observed that resident #022 still had on the same identified care supply that the resident had on when he/she was transferred from the hospital. The SDM indicated that it was only when he/she alerted the PSW on the evening shift that resident #022 received the identified care.

Review of an identified plan of care on an identified date indicated that resident #022 was to be provided an identified care during an identified time. Review of an identified assessment on an identified date indicated resident #022 required an identified care need due to an identified medical condition.

Interview with PSW #145 indicated he/she was working on an identified date, when resident #022 was admitted and indicated resident #022 was on his/her assignment. The PSW indicated he/she recalled resident #022 being admitted at an identified time during the shift and indicated that he/she had assisted another staff to provide another identified care to resident #022 and indicated that he/she did not provide the identified care that the SDM claimed was not provided as mentioned above.

Interview with RN #166 indicated he/she was the staff who admitted resident #022 on an identified date, and indicated that he/she had assessed resident #022 to have an identified medical condition that required staff to provide an identified care need. He/she indicated he/she does not recall if PSW #145 had provided the identified care to resident

#022 during the day shift when the resident was admitted.

The home failed to provide care as specified in the plan of care. [s. 6. (7)]

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

A review of a CIS submitted to MOHLTC on an identified date, indicated the resident had an unwitnessed fall incident that caused an injury to resident #036 for which the resident was taken to the hospital and resulted in a significant change in the resident's health status.

Review of the resident's progress notes, plan of care and an identified assessment on an identified date, indicated that resident was a high risk of falls due to responsive behaviours and an identified medical condition.

Review of identified home reports in an identified month indicated resident #036's had five fall incidents, two of which occurred on an identified date.
Fall #1: The resident was found in an identified position on the floor in his/her room. No injuries acquired.
Fall #2: The resident was found in an identified position on the floor with an identified injury to identified areas of his/her body.
Fall #3 and #4: The resident had two fall incidents. At an identified time resident was found in an identified position the floor outside his/her room. At an identified time the resident was found in an identified position on the floor in his/her room and had an identified injury.
Fall #5: At an identified time the resident was found on the floor in his/her room, with identified injuries to identified areas of his/her body. The resident was transferred to the hospital and the fall resulted in an identified medical condition.

Review of resident #036's written plan of care on an identified date, indicated following interventions for falls:
Check and ensure that room is clutter free. Check and ensure that floor surfaces are clean and dry.
Ensure resident wear proper identified footwear.
Resident is on an identified home's falls program for staff to monitor and prevent any

unsafe behaviour.

Further review of resident #036's plan of care indicated that it was not reviewed and revised after the two fall incidents on a identified date. The plan of care was reviewed and revised with new interventions indicated the use of identified falls prevention interventions and equipments after the resident was readmitted from the hospital on an identified date.

Interview with PSW #155 revealed that on an identified date, during the night shift he/she had found resident #036 on the floor in his/her room. The PSW further revealed that the resident did not have the identified falls prevention devices on that he/she was supposed to have.

Interview with the RN #100, Registered Practical Nurse (RPN) #137, and Physiotherapist (PT) #139 indicated that resident #036 has had the five above mentioned fall incidents between identified time periods. They further revealed that the above mentioned interventions should have been considered prior to an identified date, as the previous interventions listed on the plan of care were not effective.

Interview with the (A)DOC revealed that new interventions were not considered for resident #036's fall prevention when the resident was reassessed and his/her plan of care was being revised as required. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is been provided to the resident as specified in the plan, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home submitted a CIS on an identified date and time related to an allegation of staff to resident abuse. Review of the CIS revealed that on an identified date and time resident #006 reported to the (A)DOC that PSW #129 was provided care in an identified manner.

Review of progress note on an identified date and time, indicated resident #006 indicated to RPN #130 that PSW #129 hurt him/her during care. RPN #130 informed the night shift RN and a message was left for the (A)DOC.

Interview with resident #006 stated PSW #129 was had provided an identified care in an identified manner during the identified night shift. After the identified care was provided, resident #006 went immediately to RPN #130 and reported to the RPN that he/she was provided care in an identified manner and was hurt by PSW #129 during care.

Interview with RPN #130 stated he/she considered what resident #006 had reported to

him/her as an allegation of abuse, so he/she reported the incident to the charge nurse, RN #140. RPN #130 further indicated he/she documented on the progress notes regarding the incident.

Interview with RN #140 indicated he/she had been aware of the incident as RPN #130 reported it to him/ her at the time. The RN stated he/she instructed the RPN to document about the incident and send an electronic mail (e-mail) to the (A)DOC. RN #140 further indicated that he/she did not notify the on-call manager nor the MOHLTC after-hours, as he/she believed it was not his/her responsibility to do so as he/she was not assigned to the identified unit.

Review of the home's 2016 staff training records on zero tolerance to abuse, revealed RN #140 did not complete the training.

Interview with the Administrator stated that the most responsible person during the night shift was the RN, and that the RN should have notified the on-call manager and the MOHLTC as required, when the allegation of abuse had been reported to the staff. [s. 24. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

A review of a complaint received by the MOHLTC on an identified date, reported a concern regarding staff not providing nail care to resident #022.

Observation on an identified date and time revealed that resident #022's identified body part was in an identified state.

A review of the resident's written plan of care does not indicate an a focus and interventions for the resident's identified care need.

A review of the progress notes revealed that there was no notes indicating the resident received an identified care need from an identified service provider.

Interview with resident's #022's private duty caregiver(PDC) #002 revealed that PSWs in the home were not providing the identified care need and that he/she had never witnessed the registered staff providing the identified care need to the resident since the resident was admitted to the home on an identified date. PDC #002 confirmed that resident #022's body part were in an identified state and required an identified care to be completed.

Interview with resident #022's PDC #003, revealed that he/she never seen staff in the home providing resident #022 an identified care, and indicated that no one was providing resident #002 with an identified care.

Interview with PSW #147 and PSW #106 revealed that PSWs only completed an identified care. For the particular identified care the resident must arrange an appointment with an identified person who comes into the home to provide the identified

care service.

Interview with RN #157 revealed that generally PSWs are responsible to provide residents the identified care and for residents who have an identified medical condition, a special nurse comes in to provide an identified care service.

Interview with PSW #106, RN #157, and Resident Assessment Instrument Minimum Data Set (RAI MDS) Coordinator revealed that resident #022's identified body part was in an identified state and that the family gave consent for an identified service provider to provide an identified care service to the resident.

Interview with the Admission Coordinator confirmed that the family did not give consent for the identified service provider for the resident. [s. 35. (1)]

2. Observation by the inspector on an identified date and time, revealed that resident #011 identified body part was in an identified state and required an identified care to be completed.

A review of the resident’s written plan of care on an identified date, revealed that resident #011 identified body parts were provided an identified care on an identified time and day.

Interview with PSW #119 and RN #100 witnessed and confirmed that resident #011's identified body part were in an identified state and required an identified care to be completed. [s. 35. (1)]

3. Observation by the inspector on an identified date and time, revealed that resident #011 identified body part was in an identified state and required care an identified care to be completed. A review of the resident’s written plan of care on an identified date, indicated staff are to provide an identified care to an identified body part to the resident during an identified time and day.

A review of the progress notes revealed that there was no evidence that there was a consent signed by the resident's SDM and service provider to provide an identified care services to resident #011.

Interview with PSW #123 and RN #100 indicated that they observed that the resident #011's identified body part were in an identified state and confirmed the resident's identified body part required an identified care to be completed.

Interview with RN #100 revealed that he/she did not remember providing an identified care to the resident. As per the policy, if the SDM has signed a consent, the resident would receive an identified care services by an identified service provider, however if a consent was not signed by the SDM then it was the responsibility of the registered staff to provide the identified care to the resident. RN #100 observed the resident's identified body part with the inspector on an identified date and time and confirmed that the resident identified body part was in an identified state and required an identified care. The RN initiated the identified care immediately.

A review of an identified home's policy indicated that an identified care shall be provided by the Registered Nurse (RN).

Interview with the (C)DOC revealed that front line staff (PSWs) are not permitted to provide an identified care for residents. The (C)DOC indicated that an identified care provider provides the identified care for residents if there was a consent signed by the SDM. If the SDM has not signed a consent for an identified service provider to provide an identified care service , the registered staff in the home are responsible to provide the identified care for the resident.

Interview with (A)DOC revealed that the home is required to complete the identified care care for residents. [s. 35. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance -to ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails; -to ensure comfort and prevent infection, to be implemented voluntarily.

WN #4: 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 has failed to ensure that resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A complaint was submitted to the MOHLTC on an identified date related to the provision of care for the resident #036 including concerns related to altered skin integrity.

Review of resident #036's clinical profile indicated that resident was discharged on an identified date.

Review of resident #036's progress notes indicated that the resident had a fall on an identified date and time and sustained an identified injury to an identified area of his/her body. Further review of the progress notes indicated that the resident had another fall on an identified date and time and sustained an identified injury to an identified area of his/her body.

Further review of identified assessments of resident #036 revealed that resident did not receive an identified assessment for the two identified injuries on the identified dates.

Interview with the RN #151 indicated that he/she can recall that the resident had a fall on an identified date, and sustained an identified injury. The RN further indicated that he/she does not recall completing an identified assessment for resident #036 after the fall.

Interview with RPN #137 indicated that when a resident is observed with an area of an identified altered skin integrity, the home's practice in an identified year was to assess the resident using an identified assessment on Point Click Care (PCC). RPN #137 further indicated that after the review of resident #036's progress notes, the resident had sustained an identified skin integrity impairment to an identified area of his/her body and sustained an identified skin integrity impairment on an identified area of his/her body on an identified date due to the fall incidents. RPN #137 indicated he/she could not locate the identified assessments for the resident after the identified fall incidents.

Interview with the (A)DOC indicated when a resident has been observed with an identified altered skin integrity the registered staff are required to complete an identified assessment and that resident #036 should have received an identified assessments after the identified skin integrity impairment was noted on the identified dates. [s. 50. (2) (b) (i)]

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

During stage one of the Resident Quality Inspection (RQI), resident #002 triggered for an identified skin integrity impairment to be further inspected.

The written plan of care created on an identified date indicated that resident #002 has a history of an identified skin integrity impairments and has currently an identified skin integrity impairment to an identified area of his/her body.

The most recent written plan of care created on an identified date, indicated the resident had an identified skin integrity impairment to an identified area of his/her body.

Review of an identified home's policy stated that if a resident exhibits an identified altered skin integrity, they must be reassessed at least weekly by a member of the registered staff.

Review of the progress notes and weekly identified assessments for the period of an

identified month indicated that weekly identified assessments were not completed for several identified dates.

Interviews held with RN #102 indicated that he/she was aware of the resident #002's history of identified skin integrity impairments and that during an identified month the identified skin integrity impairments were present. Further interviews held with RN#102, the (C)DOC and the Continuous Quality Improvement (CQI) Manager confirmed that a weekly assessment is required for all residents that presented with identified altered skin integrity and that weekly assessments were not completed for the identified periods indicated for resident #002. [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 to ensure that resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #5: 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 has failed to ensure that (a) drugs were stored and complies with manufacturer's instructions for the storage of the drugs.

Review of a complaint submitted to the MOHLTC reported improper care and staff abuse regarding resident #022.

Interview with resident #022's SDM indicated that on an identified date, resident #022 was administered an identified medication treatment to manage an identified medical condition. He/she indicated that it was reported by resident #022's PDC #001 that he/she had observed the identified medication treatment that was being administered to the resident indicated an expired date.

Review of resident #022's physician orders on an identified date, indicated an order for resident #022 to receive an identified medication treatment.

Review of the progress notes between an identified date, indicated resident #022 was initiated an identified medication treatment on an identified date. Further review of the progress notes indicated that on an identified date, resident #022's PDC caregiver #001 reported to a registered staff member that the identified medication treatment that was being administered to the resident had an expired date on the identified medication treatment The incident was reported to the (C)DOC by the registered staff member for follow up.

Interview with resident #022's PDC #001 indicated he/she had observed on an identified date, the identified medication treatment that was being administered to the resident had an expired date and indicated he/she alerted RPN #110 immediately about the incident.

Interview with RPN #110 indicated resident #022's PDC #001 reported to him/her that identified medication treatment that was being administered had an expired date and indicated that he/she went to resident #022's room and observed the identified medication treatment to have an expired date on it but could not recall the date. The RPN stated he/she followed up immediately and informed the (C)DOC about the incident who followed up.

Review of resident #022's medication incident report dated an identified date, indicated the identified medication treatment administered to resident #022 was dated on an identified date, and had expired six months earlier.

Interview with the Director of Care (DOC) Clerk #173 indicated that he/she has the responsibility to order and to ensure that the nursing floors have identified medical treatment supplies in stock. He/she indicated that he/she and the registered staff share the responsibility of monitoring to ensure all medications in stock in the medication rooms are checked for their expiration dates.

Interviews with RN #100, #159, #151 and RPN #110 indicated that it is the responsibility of the registered staff administering any medication to ensure that the expiration date of the medication is checked to ensure the medication is not an expired medication prior to administering the medication.

Interviews with the (A)DOC and (C)DOC indicated that resident #022 was administered an expired medication treatment and confirmed this was a medication incident. They indicated the registered staff are responsible to ensure that any medication administered is not expired prior to administering it and indicated the staff failed to do this. [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 to ensure that (iv) that (a) drugs are stored and complies with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate actions had been taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs.

During stage one of the RQI, resident #006 mentioned to the inspector that on the evening of an identified date, he/she found an identified medication in a medicine cup that he/she alleged was not ordered for him/her, in an identified area of his/her room.

Interview with RPN #143 stated that on an identified evening, he/she found an identified medication in a medicine cup in an identified area of the resident's room. The RPN asked resident #006 why he/she had the identified medication there and the resident responded

to the RPN to ask what the identified medication was. RPN #143 queried if it was an identified medication of the resident or an identified medication of the resident's from the previous evening shift. The RPN discarded the identified medication afterwards. The RPN indicated he/she did not document about the incident nor filled out a medication incident report. RPN #143 further indicated that the (A)DOC discussed the medication error guidelines and protocol with him/ her afterwards, and as per protocol, that he/ she should have written a medication incident report when he/she discovered the unaccounted identified medication in the resident's bedroom.

Review of RPN #143’s counseling memorandum on an identified date revealed he/she was reminded by the (A)DOC that he/she was expected to report all medication errors/incidents.

Interview with the (A)DOC confirmed the above mentioned incident and indicated that a medication incident report should have been filled out by RPN #143 in response to the medication incident. [s. 134. (b)]

2. The licensee has failed to ensure that there was a documented reassessment of each resident’s drug regime at least quarterly.

Review of resident #028’s chart revealed he/she was admitted on an identified date. Review of the physician order forms between an identified periods did not identify that a three month medication review had been completed by the physician.

Interview with RN #100 confirmed that resident #028 was admitted on an identified date, and that the three month medication review was supposed to be completed on an identified date. He/she further indicated that a three month medication review had not been completed for resident #028 since he/she was admitted to the home.

Interview with the (C)DOC acknowledged that resident #028's three month medication review was not completed for resident #028, and that the home's expectation was for the quarterly review of the resident's medication to be completed by the physician every three months. [s. 134. (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that appropriate actions is taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provided direct care to residents, received training relating to abuse recognition and prevention: annually, or as determined by the licensee, based on the assessed training needs of the individual staff member.

Record review of the home's 2016, staff training records on zero tolerance to abuse, revealed an identified number of staff did not complete the training.

Interview with the (A)DOC confirmed the identified number of staff did not complete the training on zero tolerance to abuse in 2016. [s. 221. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the training on the home's Zero Tolerance of Abuse is provided to all direct care staff, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A medication administration observation was carried out on an identified date, time and location inspector #653 observed RPN #107 administer medications to residents #028, #029, and #030 consecutively.

The inspector observed that RPN #107 did not perform hand hygiene before administering resident #028's medications, and did not perform hand hygiene before and after administering resident #029 and #030's medications.

Interview with RPN #107 acknowledged the above mentioned observations, and he/ she indicated that the home's expectation is for registered staff to perform hand hygiene before and after administering medications to residents.

Interview with the Infection Prevention and Control Lead (IPAC) confirmed that the home's expectation was for registered staff to perform hand hygiene in-between residents when administering medications. [s. 229. (4)]

2. The inspector, PSWs #118 and #119 observed on an identified date, time and location, an identified resident transfer equipment was dirty and was covered with an unidentified substance on identified areas of the transfer equipment.

Interviews with PSWs #118 and #119 stated that the PSWs on all shifts are responsible to clean and disinfect the identified transfer equipment after a resident has used it. The PSWs indicated that the identified transfer equipment was dirty and should have been cleaned and disinfected after use. They confirmed that the identified transfer equipment that was observed was not clean and disinfected.

Interview with RN #100 indicated that he/she observed the identified transfer equipment to be dirty after the inspector had observed it because a staff member reported it to him/her. The RN indicated that PSWs are responsible to clean and disinfect any transfer equipment after it had been used by a resident and stated this was not done.

Interview with the (A)DOC indicated that the PSWs are responsible to clean and disinfect any transfer equipment after it has been used by a resident. [s. 229. (4)]

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A complaint was submitted to the MOHLTC on an identified date related to the provision of care for resident #036 including concerns related to monitoring of the resident during an identified medication treatment administration.

Review of the resident's clinical file indicated a PRN (as needed) physician order on an identified date indicated that the identified medication treatment to be administered at an identified rate and level. Further review of the physician orders indicated another order dated on an identified date after resident #036's readmission from the hospital, stated to continue the identified medication treatment at an identified level and rate to manage the resident's identified medical conditions.

Review of resident #036's Medication Administration Records (MARs) on an identified

date, did not indicate that the above mentioned physician orders were scheduled on the MARs.

Review of an identified home's policy indicated:
-All PRN orders must include dose, frequency, maximum to be given in 24 hrs, and the indication of PRN medication.
-If using order management Point Click Care (PCC), it is a requirement for the order to be visible on the electronic MAR.

Interview with the RN #100 indicated that the home's procedure is that all identified medication treatment orders are required to be transcribed and scheduled to come up on MAR once per shift for the register staff to assess the resident. The (A)DOC indicated that the order on an identified date, did not include frequency of how often the resident should be checked.

Review of the resident's progress notes did not indicate that he/she had been assessed for an identified treatment administration each shift after the physician order on an identified date.

Interviews and review of the MARs and physician order with RN #100, DOC #131 and the (C)DOC indicated that the two above mentioned physician orders on two identified dates had not been transcribed to his/her MAR as required by the home's policy and procedure. [s. 8. (1) (a)]

2. Review of a complaint submitted to MOHLTC on identified dates reported improper care and staff abuse regarding resident #022.

Review of resident #022's electronic medication administration record (eMAR) on an identified date, did not show evidence that the physician order for an identified medication treatment.

Interview with RN #160 indicated that he/she was the nurse who received the physician's order for resident #022 to have an identified medication treatment on an identified date when the resident was readmitted from the hospital. RN #160 indicated that if resident #022 was admitted during the day, the physician orders, the pharmacy would be able to generate physician orders into the eMAR/eTARs (electronic Treatment Administration Records). He/she further indicated that because resident #022 was readmitted from the hospital during after hours, any physician orders would not have be generated on to the

eMAR/eTARs until the next day as the pharmacy was no longer accepting orders for the day. The RN indicated that the home's practice when there are physician orders are received after hours, it is the responsibility of the registered staff to transcribe the medication order to the eMAR using PCC. He/she stated and he/she did not complete this task and therefore the physician order for resident #022 to receive an identified medication treatment was not transcribed to the MAR.

Interviews with RN #100, #159, and #157 indicated that during the day the medication orders are sent electronically to the pharmacy and is generated to the e-MAR. However, when a medication is ordered after hours during the evenings and nights, the home's practice is for the registered staff to transcribe the medication order manually by entering the medication order in PCC.

Interview with the (A)DOC indicated that staff are responsible to transcribe the medication order in the eMAR manually if they receive the medication order during after hours. He/she indicated the registered staff who received the medication order did not complete this requirement. [s. 8. (1) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, that the resident was assessed and that where the condition and circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of a CIS submitted to the MOHLTC on an identified date, indicated an unwitnessed fall incident on an identified date, that caused an injury to resident #035 for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

Review of resident #035's progress notes and fall assessments indicated that the resident had high fall risk due to identified impairments related to identified medical conditions.

Review of the resident's progress notes from identified periods, indicated that resident fell on identified dates from his/her identified mobility aide, a total of five times, without any significant injury prior to the fall on an identified date.

Review of the resident's identified Fall Assessments indicated that there were no post fall assessment completed after the fall on an identified date, when resident had a fall from his/her identified mobility aide while self transferring.

Interviews with the RPN #110 and #137 indicated that as per the home's practice in an identified year an identified fall assessment should have been completed by a registered staff after each fall. They further reviewed the resident's assessments and progress notes and revealed that the post fall assessment was not completed after the fall on an identified date for resident #035 as required.

Interview with the (A)DOC indicated that registered staff is required to complete an identified Fall Assessment after a resident has fallen and resident #037 did not receive the post fall assessment after the fall mentioned above on an identified date. [s. 49. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Review of a complaint submitted to the MOHLTC on an identified date, indicated an allegation of abuse.

Interview with resident #002 indicated that he/she had reported to the home on an identified date and time, that two of his/her identified personal care items that had an identified brand name were missing from his/her room after he/she had returned from an identified appointment. Resident #002 indicated that he/she suspected that the PSW that was assigned to him/her that evening may have taken the identified personal care items without his/her permission.

Review of resident #022 during an identified period did not indicate any information regarding the above missing personal care items.

Review of an identified home's document indicated documentation that recorded the

above concern from resident #002 that the staff had searched for the missing identified personal care items in the resident's room but could not locate them and that the staff would continue to monitor. The document indicated the Administrator was to speak to the PSW who was assigned to the resident that evening but there was no further documentation regarding this. Further review of the document did not indicate any documentation of the follow up with the resident.

Interview with resident #002 indicated that he/she recalled the Administrator speaking to him/her about the complaint but could not recall the date of this conversation.

Interview with the Administrator indicated when a resident has a concern or complaint, the home uses an identified home document to document the concern, investigation, action taken and family response to the follow up and he/she indicated the home initiated this record for resident #002's complaint. The Administrator indicated the home had completed an investigation on resident #002's complaint and the identified personal care items were apparently found and indicated that he/she visited resident #002 and informed him/her of the outcome of the investigation but could not recall the date of the visit. The Administrator indicated that the home's practice is to ensure that the home keeps a record of the investigation and that the record is complete and he/she stated he/she did not do this. [s. 101. (2)]

Issued on this 19th day of October, 2017

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

Original report signed by the inspector.