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

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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
Nov 08, 2019	2019_767643_0027 (A1)	008748-18, 009053-18, 009456-19, 011032-19, 011033-19, 011034-19, 014079-19, 017624-19	Complaint

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Hawthorne Place Care Centre
2045 Finch Avenue West NORTH YORK ON M3N 1M9

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

Amended by ADAM DICKEY (643) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee report edited to change the title of the document reviewed in WN #2 finding #2 for resident #001 from eMAR to medication administration audit report.
Licensee Order report edited to change the title of the document reviewed in the grounds for CO#003 for resident #001 from eMAR to medication administration audit report.

Issued on this 8 th day of November, 2019 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by ADAM DICKEY (643) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 16, 17, 19,

20, 23-27, 30 and October 1, 2019.

The following Compliance Order follow-up intakes were inspected during this inspection:

Log #011032-19 - related to advance care directives;

Log #011033-19 - related to prevention of abuse; and

Log #011034-19 - related to medication administration.

The following Complaint intakes were inspected during this inspection:

Log #009456-19 - related to continence care, falls prevention and management, skin and wound care and pest control;

Log #008748-18 - related to hospitalization and change in condition;

Log #014079-19 - related to nutrition and hydration and skin and wound care;

Log #009053-18 - related to nutrition and hydration and medication management; and

Log #017624-19 - related to skin and wound care.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOC), Physician, Nurse Clinician from Responsive Healthcare, Registered Physiotherapist (PT), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Environmental Services Manager (ESM), Food Services Supervisor, Staff Development Coordinator, Unit Clerk, Personal Support Workers (PSW), Dietary Aides (DA), Housekeeping Aides (HA), residents and family members.

During the course of the inspection, the inspectors conducted observations in the home and resident areas, observation of care delivery processes including medication passes and meal delivery services, and review of the home's policies and procedures and residents' health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2019_746692_0013	665

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for resident #004 set out the planned care for the resident related to care for an area of altered skin integrity.

A complaint was received by the Ministry of Long-Term Care (MLTC) related to concerns about resident #004's skin condition.

Review of the progress notes for resident #004 indicated that in an identified

month, the resident had 12 specified alterations in skin integrity. Notes on an identified date in the above mentioned month indicated that the resident had a dressing in place for a specified area of altered skin integrity. The following day, a note indicated that a skin and wound assessment was completed for the area. A third note on the third consecutive day indicated that the resident had another new area of altered skin integrity identified, and that a dressing was applied (no further details provided regarding the area of altered skin integrity or treatment).

Review of the assessments in the electronic documentation system indicated that a skin and wound assessment was completed for resident #004's first above identified area of altered skin; a skin and wound assessment was not identified for the second above identified area of altered skin integrity. The orders and electronic treatment administration record (eTAR) were reviewed, and there were no treatments specified for the two above identified areas of altered skin integrity.

RPN #133 indicated in an interview that treatments for resident's alterations in skin integrity should be entered directly into the electronic documentation system by the wound care nurse, which populated the eTAR entry and prompted registered staff to provide the treatment as per the home's wound care protocol. They further indicated that the home's wound care nurse usually completed the weekly treatments for residents' altered skin integrity, but that the unit nursing staff were required to provide the treatments if the wound care nurse was unable or unavailable. The RPN acknowledged that there was no order or entry in the eTAR for resident #004's two above identified areas of altered skin integrity, but indicated that they were providing the treatments based on the home's wound care protocol.

RPN #109, the home's wound care nurse, confirmed that they should enter the treatments for residents' alterations in skin integrity directly into the orders in the electronic documentation system, and that those orders populated the eTAR. They acknowledged that all treatments for resident #004's skin alterations should have been entered into the eTAR, to ensure that staff provided the wound treatments as ordered. RPN #109 confirmed that there were no orders or eTAR entries for resident #004's two above identified areas of altered skin integrity.

The DOC confirmed in an interview that the written plan of care for resident #004 did not set out the planned care for their two identified areas of altered skin integrity, and the required treatments were not documented in the orders or eTAR. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of residents #002 and #010's needs and preferences.

a. A complaint was submitted to the MLTC from a family member of resident #002. The complainant indicated that the home was not properly managing the resident's nutritional care.

Review of resident #002's written care plan showed they required assistance for feeding.

In interviews, PSW #102, PSW #104 and RPN #105 indicated that resident #002 required assistance with feeding, however the resident did not always accept the feeding assistance from staff. PSWs #102, #104 and RPN #105 indicated that at times resident #002 would be able to feed themselves, and other times would require staff to assist them.

In an interview, RD #106 indicated that resident #002 should be provided assistance with feeding, though the resident did not like to be assisted, and would feed themselves at times. RD #106 acknowledged that resident #002's plan of care was not based on an assessment of their preference not to receive assistance with feeding.

b. As a result of identified noncompliance with LTCHA 2007, c. 8, s. 6. (7) for resident #004, the sample of residents reviewed was expanded to include resident #010.

Review of resident #010's current written care plan showed they were at risk for falls, and had specified falls prevention interventions in place. Review of resident #010's progress notes showed that on an identified date, the resident was assessed by PT #132 who indicated identified equipment should be used, and if refusing registered staff should document the refusal. A progress note one week later, showed resident #010 had refused the identified equipment.

In an interview, PSW #135 indicated that resident #010 had falls prevention interventions in place, including the above identified equipment. PSW #135 indicated that they would encourage resident #010 to use the identified equipment but the resident had refused to have the equipment in place. PSW #135 indicated that they had reported to the registered staff that resident #010 had refused to

have the identified equipment in place in the past.

In an interview, resident #010 indicated that the above identified equipment was available to them, but they did not like to use it. The identified equipment was located by PSW #135, which the resident refused to allow the PSW to apply.

In an interview, RPN #139 indicated that resident #010 had specified fall interventions in place, including use of the above equipment. RPN #139 indicated that resident #010 had been known to be non-compliant with the use of the identified equipment. The RPN indicated that staff would encourage resident #010 to use the equipment, but the resident would frequently refuse. RPN #135 indicated that the resident's preference to not use the identified equipment was not included in the care plan and should have been.

In an interview, ADOC #115 indicated that when resident #010 refused to use the identified equipment, the written care plan should have been updated to include instruction to staff that the resident may refuse, and their preference should be included in the care plan. ADOC #115 acknowledged that the plan of care was not based on an assessment of resident #010's preference. [s. 6. (2)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #002 and #004 as specified in the plan.

On May 31, 2019, the following Compliance Order (CO #001) from inspection report 2019_746692_0013; amended on June 3, 2019, inspection report #2019_746692_0013 (A1) made under LTCHA 2007, c. 8, s. 6. (7) was issued:

The licensee must be in compliance with s. 6. (7) of the LTCHA.
Specifically the licensee must:
a) Ensure all residents' Advance Directives are followed as per the residents wishes.
b) Educate/re-educate all relevant staff on the process related to various Advance Directives.
c) Maintain records, including the attendees, date(s), and material reviewed.

a. Review of resident #002's current written care plan showed the resident required assistance with feeding. The care plan further showed resident #002 was to be provided with two specified snacks and a specified beverage at an identified snack pass.

Observations by Inspector #643 on an identified date, showed resident #002 seated at a dining table with one of the above specified snacks and the above specified beverage on the table. No staff were present to assist with feeding resident #002 their snack. Further observation the following day showed resident #002 seated at the dining table with one of the above specified snacks and the above specified beverage on the table. A spoon was in resident #002's hand; however, no staff were present assisting the resident to consume their snack.

In an interview, PSW #104 indicated that they had provided residents on the unit with the above identified snack pass on the first above identified date. PSW #104 indicated that residents who required assistance with eating would be served snack by the PSW completing snack pass, who would also stay with the residents and assist them with feeding. PSW #104 further indicated that resident #002 received the above specified snacks and beverage. They would show the resident the items and resident #002 did not always choose to have one of the specified snacks. PSW #104 indicated that they would open the snack container for resident #002 and put the spoon inside and let resident #002 know that it was time for the snack. PSW #104 further indicated that resident #002 did not prefer assistance with feeding and would leave the snacks with the resident to consume themselves.

Observations by Inspector #643 on a third identified date showed resident #002 could not be located on the unit while staff provided the above identified snack pass. PSW #102 indicated that the resident might be off the unit with family, or in an off unit activity. The inspector observed resident #002's above specified snacks and beverage in an ice bath on the snack cart. The inspector located resident #002 in another resident area of the home. The resident was observed to have returned to the unit approximately 25 minutes later, and was seated at their table in the dining room with no snack provided.

In an interview, DA #128 indicated that the snack cart was returned to the servery on the unit and their co-worker had returned it to the main kitchen. Inspector #643 interviewed DA #121 who indicated that when a resident does not take a labeled snack, it is returned to the main kitchen from the unit servery. DA #121 further indicated that resident #002's labeled snacks were returned to the main kitchen on the third identified date.

In an interview, PSW #140 indicated that they had provided the identified snack

pass to residents on the unit on the third identified date. PSW #140 indicated that when they provided snacks, resident #002 was not present on the unit to receive their snack, and did not provide it. PSW #140 indicated that there was no process in place to reserve a labeled snack for a resident who was not on the unit when snack pass occurred, and they would document in point-of-care (POC) indicating resident not available.

In an interview, ADOC #115 indicated that when a resident was to receive a labeled snack, according to their plan of care, staff were expected to provide the snack to the resident. The ADOC indicated that when a resident was going to an off unit activity, the staff would still be expected to provide the snack as per the resident's plan of care. The ADOC indicated that if a resident had an activity scheduled at the same time as snack pass, arrangements should be made to ensure that the resident receives their labeled snack as ordered by the RD.

In an interview, RD #106 indicated that resident #002 was to receive both specified snacks at the identified snack pass, with the specified beverage as indicated in the written care plan. RD #106 further indicated that resident #002 was to be provided assistance with feeding, though the resident did not prefer to be assisted and would feed themselves at times with supervision from staff. RD #106 indicated that as resident #002's care plan instructed staff to provide assistance with feeding, a staff member should be with resident #002 during snack pass to supervise and provide the assistance required when needed.

b. A complaint was submitted to the MLTC by resident #004's family member with concerns about multiple care areas including falls sustained by the resident. The complainant indicated that the home reported to them on several occasions that resident #004 had been found on the floor.

Review of resident #004's current written care plan showed they were at risk for falls and had falls prevention interventions in their care plan, including to ensure specified equipment was in place at all times. The care plan showed resident #004 had been noted by staff to remove the above specified equipment at times.

Observations conducted by the inspector on an identified date, showed resident #004 in bed; the resident did not appear to have the above specified equipment in place. Approximately 40 minutes later, the inspector observed resident #004 with RPN #105, who checked the resident for the above specified equipment and indicated they were not in place. RPN #105 looked for the equipment in resident

#004's room and found a portion of the equipment which was not complete.

In an interview, PSW #127 indicated that they had been providing care to resident #004 for the last 10 months, and had not been aware that the use of the above specified equipment was included in their written care plan or kardex. PSW #127 indicated that they did not ensure that the specified equipment was in place for resident #004, and the resident had not been using it during their shift.

In an interview, RPN #105 indicated that they were aware of resident #004's fall risk and history of falls. RPN #105 indicated that resident #004 had interventions in place including the above specified equipment. They indicated that resident #004 should be using the specified equipment at all times, and acknowledged that the resident was not using it that day. RPN #105 indicated that the equipment should be kept in the resident's room, and had located a portion of the equipment but it was not complete.

In an interview, interim ADOC #111 indicated that the specified equipment would be provided by the nursing staff for residents who were assessed to need it to prevent injury from falls. ADOC #111 indicated that when a resident received the specified equipment, they were provided with two sets, in case one was in the laundry or dirty. ADOC #111 indicated they were not aware that resident #004 did not have the specified equipment available, and that management could provide another set if lost. They indicated that as resident #004 did not have the equipment in place, and did not have the equipment available, the care was not provided as specified in resident #004's plan of care. [s. 6. (7)]

4. The home has failed to ensure that the provision of the care set out in the plan of care was documented for resident #001.

A review of resident #001's quarterly medication review for an identified three month period, showed the resident had an order for a specified medication to be administered at three identified times daily, and a second specified medication to be administered twice daily at two of the three scheduled administration times with the first identified medication. A review of resident #001's electronic medication administration record (eMAR) did not show documentation that the two medications noted above were administered on an identified date for two scheduled administrations during an identified shift. .

In an interview, RPN #143 indicated it was the home's process to document in the

eMAR that medications were administered soon after they have been given to the residents. The RPN confirmed they were the assigned nurse on the above shift on the identified date, and had administered the medications noted above to resident #001 at the scheduled time, but missed documenting in the eMAR.

In an interview, DOC #101 indicated it was the home's expectation for registered staff to sign the eMAR right away when medications have been administered to residents. The DOC acknowledged that RPN #114 did not document the administration of the above medications to resident #001 in the eMAR on the above identified date. [s. 6. (9) 1.]

5. The licensee has failed to ensure that resident #004 was reassessed and had their plan of care reviewed and revised when the resident's care needs changed related to their bowel elimination pattern.

A complaint was received by the MLTC, related to concerns about resident #004's continence care. The complainant indicated they were concerned when they found resident #004 soiled without an incontinence product, and a staff member indicated that they would return after break to care for the resident.

Review of the progress notes indicated that resident #004 had been hospitalized and returned to the home on an identified date, with a specified infection, which was being treated in the home. The progress notes indicated that the resident had multiple loose bowel movements (LBM) on most days in a 20 day period beginning two days after returning from hospital. A note by resident #004's physician dated nine days after returning from hospital, indicated that the resident was having multiple LBMs per day.

Review of the documentation starting the day after returning from hospital through the following month, indicated that the resident had LBMs on almost every shift. PSWs #124 and #127 both confirmed in separate interviews that the resident was having frequent LBMs during the above mentioned time, which was an ongoing issue for the resident that required frequent continence care.

The Resident Assessment Instrument – Minimum Data Set (RAI-MDS) assessments in the electronic health record were reviewed for resident #004. The RAI-MDS quarterly assessments from an identified date in the month prior to returning from hospital, and an identified date two months after returning from hospital, both indicated that the resident had a regular bowel elimination pattern.

Resident #004's Continence Management Assessments (CMAs) were identified in the electronic health record for an identified date eight months prior to their return from hospital and a second identified date two months following their return from hospital which both indicated that the resident was incontinent, had a regular bowel pattern, and used an incontinence product. There were no other CMAs identified during this period.

Review of the home's Continence Assessment policy, last revised March 2018, indicated that registered staff were to complete a continence assessment for residents who were incontinent whenever there was a change in the resident's continence status. RPN #109, who was covering for the continence care lead in the home, indicated during an interview that registered staff were expected to use the CMA form in the electronic documentation system for the continence assessment.

Review of the written care plan and history of revisions in the electronic health record indicated that the resident was incontinent as of an identified date four months prior to their above mentioned return from hospital. The care plan showed that the resident required an incontinence product since an identified date eight months prior to their return from hospital; and was to be assisted with toileting at six specified times daily. There were no revisions to the resident's written care plan related to the resident's frequent LBMs in the two month period following their return from hospital.

RPN #109 confirmed during an interview that resident #004 was incontinent, was having frequent LBMs after they returned from the hospital on the above identified date, and that the resident was being treated for a specified infection. They indicated that the resident had a change in their bowel elimination pattern and should have had another CMA completed as per the home's policy; they acknowledged that the CMA and RAI-MDS assessments identified above did not accurately reflect the resident's bowel elimination pattern. They also acknowledged that there were no revisions to resident #004's written care plan related to frequent LBMs, and that the home could have implemented various specified interventions to address the care needs related to the change in bowel elimination pattern.

The DOC acknowledged during an interview that resident #004's bowel elimination pattern had changed after their above hospitalization, they were not

reassessed as required by the home's policy when there was a change in the resident's continence status, and that the resident's plan of care was not revised to reflect a change in the resident's continence care needs. [s. 6. (10) (b)]

Additional Required Actions:

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

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure:
- that the written plan of care for each resident sets out the planned care for the resident;
- 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; and
- that the resident is reassessed and the plan of care is reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 residents #002 and #004 who were exhibiting altered skin integrity 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. A complaint was submitted to the MLTC from resident #002's family member related to care concerns, including skin and wound care related to specified areas of altered skin integrity which were reported to them. The complainant stated that the areas of altered skin integrity were not healing.

Review of resident #002's progress notes showed that on an identified date, RPN #122 noted two specified areas of altered skin integrity. According to the progress note, RPN #122 attempted to clean the site with an identified antimicrobial agent and assess further; however, the resident did not allow for the assessment to be completed. The progress notes showed that a skin and wound referral was initiated the same day, for the new areas of altered skin integrity. Progress notes further showed that RPN #107 attempted to assess the areas on the following day, though resident #002 refused to allow the RPN to touch the general area around the altered skin integrity. A progress note four days following the discovery of the specified areas of altered skin integrity, showed RPN #109, who was the skin and wound care lead in the home, saw resident #002, and unsuccessfully

attempted to assess the resident and would follow-up.

Review of the assessments in the electronic health record did not show an assessment for the above mentioned areas of altered skin integrity. Review of resident #002's electronic treatment administration record (eTAR) showed a specified treatment order was initiated 12 days following the discovery of the areas of altered skin integrity to be carried out twice daily. No previous treatment order was found related to resident #002's areas of altered skin integrity.

In an interview, RPN #122 indicated that the process in the home was when a new area of altered skin integrity was discovered a referral should be sent to the skin and wound care lead to do an initial assessment of the area and treat according to the home's wound care algorithm. The RPN indicated that they had received a report from a PSW staff about the altered skin integrity for resident #002 on the above identified date. RPN #122 indicated that they had noted the above areas of altered skin integrity, though the resident was not allowing the RPN to assess the areas. RPN #122 indicated that they completed a referral to the skin and wound lead to assess the area and communicated to the oncoming shift to follow up.

In an interview, RPN #109 indicated that the process in the home when a new area of impaired skin integrity was discovered was for registered staff to do an initial assessment of the area and provide treatment according to the home's skin and wound care algorithm. RPN #109 further indicated that the home was utilizing a smartphone application to generate a complete skin and wound assessment using pictures to document progression of an area of altered skin integrity and effectiveness of treatment. They indicated that they had received a referral for resident #002's above specified areas of altered skin integrity and attempted to assess four days following the discovery of the areas, though the resident refused three times. RPN #109 indicated that there had been no further attempts made to complete an assessment, and that the area was not assessed using the clinically appropriate assessment tool specifically designed for skin and wound assessment.

b. A complaint was received by the MLTC related to concerns about resident #004's skin integrity.

Review of the progress notes and eTAR indicated that in an identified month, the resident had 12 specified alterations in their skin integrity, including three

identified areas of altered skin integrity of a specified type.

The skin and wound assessments for resident #004 were reviewed by Inspector #722 in the progress notes and assessment tab in the electronic health record. No skin and wound assessments were identified using an assessment tool that included basic wound assessment details (i.e., location, size, drainage, signs of infection, and treatment) for the three above identified areas of altered skin integrity.

The home's Wound Assessment Documentation policy, last revised April 2010, indicated that registered staff were required to include the following in their wound assessment documentation: status, location, size, drainage, odour, necrotic tissue, signs of infection, and treatment. There were no progress notes or assessments for the three identified areas of altered skin integrity that documented this information.

RPN #133 indicated during an interview that for any new alteration in skin integrity, the registered staff were expected to complete an initial assessment of the wound and enter their findings in the electronic record, using one of two specified skin alteration documentation tools. They acknowledged that neither of these tools were used for the three above identified areas of altered skin integrity for resident #004. The RPN indicated that they were also expected to send a referral to the home's wound care nurse, who completed wound assessments for all residents each week using a smartphone application.

RPN #109, the home's wound care nurse, indicated that when they received a referral, they would assess residents' areas of altered skin integrity using an assessment application on a smartphone, which included a photograph of the area, and all the assessment details required according to the home's assessment policy. The RPN stated that the wound assessment information from the smartphone application populated the Skin & Wound Evaluation V6.0 form in the electronic health record. RPN #109 confirmed that the Skin & Wound Evaluation V6.0 was not completed for resident #004's three identified areas of altered skin integrity.

The DOC confirmed that resident #009's three identified areas of altered skin integrity should have been assessed using the smartphone application that populated the Skin & Wound Evaluation V6.0 form in PCC. They acknowledged that there was no assessment completed using a clinically appropriate tool for

resident #004's three identified areas of altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that resident #002, who was exhibiting altered skin integrity, received immediate treatment and interventions to promote healing and prevent infection as required.

Review of resident #002's progress notes showed that on an identified date, RPN #122 noted two specified areas of altered skin integrity. According to the progress note, RPN #122 attempted to clean the site with an identified antimicrobial agent and assess further; however, the resident did not allow for the assessment to be completed. The progress notes showed that a skin and wound referral was initiated the same day, for the new areas of altered skin integrity. Progress notes further showed that RPN #107 attempted to assess the areas on the following day, though resident #002 refused to allow the RPN to touch the general area around the altered skin integrity. A progress note four days following the discovery of the specified areas of altered skin integrity, showed RPN #109, who was the skin and wound care lead in the home, saw resident #002, and unsuccessfully attempted to assess the resident and would follow-up.

Review of the assessments in the electronic health record did not show an assessment for the above mentioned areas of altered skin integrity. Review of resident #002's electronic treatment administration record (eTAR) showed a specified treatment order was initiated 12 days following the discovery of the areas of altered skin integrity to be carried out twice daily. No previous treatment order was found related to resident #002's areas of altered skin integrity.

In an interview, RPN #122 indicated that they received a report from one of the PSW staff that resident #002 had a new area of altered skin integrity. RPN #122 indicated that when a resident is discovered to have a new area of altered skin integrity they would conduct an assessment of the area in terms of measurement, color, shape and document using the assessment tool in the electronic health record. RPN #122 further indicated that they would consult the home's wound care algorithm for treatment of the area to prevent the area from deteriorating. RPN #122 indicated that resident #002 had pulled away and they were unable to assess the area of altered skin integrity, or provide any treatment; they completed a progress note for the registered staff to follow up.

In an interview, RPN #107 indicated that when a resident was found to have a new area of altered skin integrity, the registered staff on the unit would conduct a

preliminary assessment and refer to the wound care nurse for full assessment. RPN #107 indicated that they would clean the area of altered skin integrity, apply an identified antimicrobial agent and apply a dressing to cover. RPN #107 further indicated that they would know what type of treatment to provide by consulting the home's wound care algorithm. RPN #107 indicated they were unable to assess and treat resident #002's altered skin integrity the day following it's discovery, as the resident refused to allow them to assess the area and they documented in the progress notes.

In an interview, the home's wound care lead RPN #109 indicated that when a new area of altered skin integrity was identified for a resident the registered staff should assess the area, enter a progress note and complete a skin and wound referral for full assessment. RPN #109 further indicated that the registered staff are expected to ensure that a treatment is provided to promote healing and prevent infection. They indicated that the registered staff would consult the home's wound care algorithm for appropriate treatment based on the type of wound. RPN #109 acknowledged that no immediate treatment was provided to promote healing and prevent infection for resident #002's above identified area of altered skin integrity. [s. 50. (2) (b) (ii)]

Additional Required Actions:

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

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 with ensuring that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that no drug was used by or administered to resident #004 unless it was prescribed for the resident.

Review of the progress notes indicated that resident #004 was having loose bowel movements (LBMs) on an identified date. A progress note entered at an identified time that day, indicated that RPN #130 administered an identified medication to decrease the frequency of LBMs.

The physician orders for resident #004 were reviewed in the chart and electronic medical record, and no active orders or medical directives were found for the above identified medication. Resident #004's eMAR was reviewed, and there was no entry in the eMAR for the identified medication.

RPN #130 confirmed in an interview that they entered the progress note above and recalled administering the above identified medication on the identified date to resident #004. The RPN could not recall if there was an as needed (PRN) physician order for the identified medication and had thought there was a medical directive in place. The RPN indicated that they went to the stock medication supply to get the identified medication for the resident and could not recall if they had signed for it on the resident's eMAR. RPN #130 explained during the interview that when they wanted to administer a drug to a resident that was not prescribed, they needed to call the on-call doctor, get an order over the phone, transcribe the telephone order into the physician's orders in the chart, and enter the new order into the eMAR. They acknowledged that residents should only be

administered medications that were prescribed by a physician.

The DOC and RPN #109 both acknowledged in separate interviews that resident #004 did not have an order or medical directive for the above identified medication, and the registered staff should have contacted the on-call physician to get an order prior to administration. Both the DOC and RPN confirmed that resident #004 was administered a medication that was not prescribed. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents #005 and #001 in accordance with the directions for use specified by the prescriber.

Compliance Order #001 was served on May 31, 2019, under inspection report #2019_746692_0012 with a compliance due date of July 16, 2019. The licensee was ordered to be compliant with r. 131. (2) of the Ontario Regulation 79/10.

Specifically the licensee was ordered to:
a) Ensure that medications are administered to residents #001, #005, #019, and any other resident, at their prescribed time;
b) Conduct and document scheduled audits of resident's electronic Medication Administration Record (eMAR); and
c) Maintain a record of the results of the audit and the actions taken to address the concerns.

a) During a review of resident #005's physician orders, a telephone order from an identified date, indicated to change the administration time of an identified medication to a specified scheduled administration time to be started two weeks after the transcription of the telephone order, and to discontinue the previous order for the identified medication. A review of the resident's eMAR for the month of the transcription of the telephone order indicated that the administration of the identified medication had been scheduled for a specified administration time and was discontinued on the date the telephone order was transcribed. Four days later, an entry for the identified medication was found which indicated the administration was scheduled for one specified time and to be changed to another specified time starting two weeks following the transcription of the telephone order.

In an interview, RPN #114 indicated that they transcribed the telephone order on the above identified date for the identified medication order for resident #005. The

RPN stated that they reviewed the order three days later, and realized they transcribed the order incorrectly and was not clear, resulting in the medication being discontinued. The RPN indicated that the intended direction of the order was only to change the time of administration starting two weeks later. The incorrect transcription of the order resulted in the resident missing three doses of the identified medication on the three consecutive dates following the transcription of the telephone order. RPN #114 acknowledged that resident #005 did not receive the identified medication as prescribed.

b) A review of resident #001's quarterly medication review for an identified three month period, showed the resident was prescribed an identified medication at three specified scheduled times daily. Review of the resident's medication administration audit report for the final two week period during the identified three month period, showed that two of the resident's specified scheduled doses of the identified medication were administered together by RPN #141 on two consecutive identified dates.

In an interview, RPN #141 confirmed they had administered the two scheduled doses of resident #001's identified medication at the same time on each of the above dates. The RPN indicated the resident exhibited responsive behaviours and would at times refuse the first scheduled dose of the identified medication. They indicated that when that occurred they would save the first scheduled dose and administer it together with the second scheduled dose. The RPN indicated they should have communicated this to the physician and documented the resident's preference in a progress note. RPN #141 confirmed they did not administer resident #001's identified medication as prescribed.

In an interview, DOC #101 indicated it was the home's expectation for medications to be administered as prescribed and at their prescribed time. The DOC confirmed that they were made aware by ADOC #113, that resident #005 missed three doses of their above identified medication. During the interview, the DOC further stated when a resident refused their medication(s), the expectation was for the registered staff to attempt to administer again after a few minutes and document in the eMAR as refused. The DOC indicated that RPN #141 should have communicated resident #001's preference for their medication administration in a progress note, and in the physician communication book. As a result of this information, the DOC acknowledged residents #005 and #001 did not receive their medications as prescribed and at the prescribed time. [s. 131. (2)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 003

WN #4: 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 that the licensee was required by the Act or Regulation to have instituted or otherwise put in place was complied with.

As required by the Act [LTCHA 2007, c. 8, s. 11. (1) (a)] the licensee was required 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. As required by the Regulation [O. Reg. 79/10, s. 68. (2) (e) (i)] the licensee was to ensure that the program included a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

Review of the home's policy titled Resident Weight Monitoring, policy #RCS C-25, last reviewed January 11, 2019, showed that residents should be weighed on admission, re-admission, monthly and recorded in the electronic health record. The policy further showed that routine weight monitoring could be discontinued if clinically indicated and confirmed by a Physician's order. The policy showed that the nurse in charge had to verify the accuracy of the weight if the weight measurement showed a discrepancy of five per-cent or two kilograms (kg) compared to the previous month by re-weighing the resident within 24 hours and entering the re-weigh value into the electronic health record. If the first weight measurement was determined to be incorrect the measurement was to be struck out as incorrect documentation.

a. Review of resident #002's weight history in the electronic health record showed that on an identified date, the resident's weight was recorded as a specified value. Resident #002's weight was recorded on a second identified date the following month as a specified value, which represented a 31.2 per-cent difference from the previous month's recorded weight. The weight history did not show a re-weigh being recorded to verify the accuracy of the weight recorded on the second above identified date.

In interviews, RPN #105 and RN #134 indicated that residents were weighed monthly by PSW staff and weights were entered into the electronic health record by the registered staff. RN #134 indicated that when there was a discrepancy between a resident's measured weight compared with the previous month's recorded weight, the registered staff would request the PSW staff to re-weigh the resident. The registered staff would then verify if the new weight was accurate and if not strike out the incorrect weight and enter the accurate weight measurement. RN #134 indicated that for resident #002, the weight recorded on the second above identified date was likely inaccurate, and staff should have completed a re-weigh for the resident to verify the accuracy of the measurement.

In interviews, RD #106 and ADOC #115 indicated that it was the expectation that when there is a discrepancy in a resident's weight measurement from the previous month of five per-cent or two kilograms, a re-weigh was to be obtained. RD #106 and ADOC #115 indicated that when a discrepancy was identified in resident #002's weight from the second identified date compared to the previous month's weight, it was the expectation for registered staff to verify the accuracy of the weight measurement. ADOC #115 indicated that it was the expectation for

staff to enter the weight measurement once verified into the electronic record and strike out the incorrect data. They acknowledged that there was no re-weigh documented for resident #002 when there was a discrepancy from the previous month, and the staff had not complied with the home's weight monitoring system.

b. A complaint was received by the MLTC regarding resident #003's nutrition and hydration care in the home. A review of resident #003's weight history was conducted as part of the inspection into this complaint. The weight history in the electronic health record showed that at the time of inspection, the resident's most recent weight was recorded four months earlier. There were no weight measurements identified for three consecutive months.

In an interview, RN #134 indicated that resident #003 should be weighed monthly at the beginning of each month by an identified shift's staff on the resident's shower day. RN #134 indicated that resident #003 may not have been weighed because the resident has been hospitalized at times, and may have been missed at the beginning of the month. RN #134 indicated that there was no clinical indication to discontinue monthly weights for resident #003. RN #134 indicated that there was no physician's order to discontinue monthly weights for resident #003.

In an interview, ADOC #115 indicated that it was the policy of the home for all residents to be weighed monthly and have their weights recorded in the electronic health record. ADOC #115 indicated that resident #003 should have been weighed monthly regardless of their mostly bed-bound status. ADOC #115 indicated there was no clinical reason for resident #003 to not have monthly weights recorded, nor was there a physician's order discontinuing monthly weights. The ADOC acknowledged that the staff had not measured and recorded resident #003's weight monthly for three consecutive months, and had not complied with the home's weight monitoring system. [s. 8. (1) (a),s. 8. (1) (b)]

2. In accordance with the Regulation [O. Reg. 79/10, s. 114 (2)], the licensee was required to have written policies and protocols 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.

Specifically, staff did not comply with the following medication management policies:

- Medication Administration, index #RCS F-05, last reviewed June 11, 2018. The policy indicated under signature and initials, number three, that all medications administered must be signed off electronically as given by the registered staff as soon as the medications have been given.

- Transcribing physician's orders or RN (EC)'s Orders, index #RCS F-65, revised date August 22, 2019. The policy indicated under procedure number 13, that after transcription is complete, the nurse signs off order on Physician's Order Sheet indicating full signature, status, date and time that order was transcribed.

a. During a review of the medication administration audit reports for residents #001, #005 and #019 for an identified three month period, the reports indicated that medications were documented as administered past the scheduled administration time in the residents' eMAR.

i. The medication administration audit reports for resident #001's identified medication, which was to be administered at three specified times daily were documented as administered past the scheduled administration times on four identified dates as follows:

-identified date #1 - two hours and 46 minutes late, documented by RPN #141;
-identified date #2 - two scheduled doses were administered together by RPN #143, one dose six hours and 52 minutes late, and one dose two hours and 52 minutes late;
-identified date #3 - two hours and 21 minutes late, documented by RPN #141; and
-identified date #4 - five hours and 49 minutes late, documented by RPN #143.

The resident's medication order for a second identified medication, scheduled to be administered at an identified time was documented as administered two hours late on an identified date, by RPN #133.

ii. The medication administration audit reports for resident #005 indicated that on a specified date the scheduled doses of two identified medications were documented as administered five hours and 22 minutes late by RPN #143.

iii. The medication administration audit reports for resident #019 indicated that five identified medications were to be administered at a specified time, and were

documented as administered four hours and 13 minutes late on an identified date by RPN #144.

In interviews, RPNs #133, #141, #143 and #144 indicated it was the home's policy for medications to be documented as given in the resident's eMAR right after administration. The RPNs indicated they had administered the residents' medications at their scheduled times but documented late in the eMAR. The above staff acknowledged that they did not follow the home's policy on medication administration.

b. During a record review of resident #005's physician orders, a medication order from an identified date, did not have documentation as to the time the order was transcribed and processed by the registered staff. A review of the physician's order sheet directed staff to include the date and time when the order was transcribed and checked as per the home's policy. The sample was expanded to include residents #001 and #019.

A review of resident #001's physician orders showed an order from an identified date, which indicated to stop all administrations of an identified medication. Resident #019 had a physician order from an identified date, to add an identified medication to be administered daily. The physician order sheets for residents #001 and #019 did not have the time the orders were transcribed by the registered staff.

In an interview, RN #134 and RPN #114 indicated that when medication orders are processed, it is the home's policy for the registered staff to sign and date when the orders have been transcribed. Both registered staff indicated they were not aware that they were to document the time transcribed in the physician order sheets. The RN and RPN reviewed the policy and indicated that the time was not documented when orders were transcribed for residents #001, #005 and #019.

In an interview, DOC #101 indicated that it was the home's policy for the registered staff to document in the eMAR immediately after the medications are administered. The DOC stated the home had done medication administration audits and were aware that the registered staff did not immediately document in the eMAR when medications were given resulting in late documentation in the eMAR. During the interview, the DOC reviewed the home's policy on transcribing physician's orders and the physician orders for residents #001, #005 and #019. The DOC indicated that it was the expectation for the registered staff to document

the time the residents' orders were transcribed and processed. They further stated that the physician order sheet even directed the staff to document the time the order was processed and checked. The DOC acknowledged that the registered staff did not follow the home's medication management policies noted above for residents #001, #005 and #019. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter as required by the Regulation [O. Reg. 79/10, s. 68. (2) (e) (i)] is complied with; and
to ensure that the written policies and protocols for medication management as required by O. Reg. 79/10, s. 114 (2) are complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

A complaint was received by the MLTC on an identified date, from resident #004's family member regarding care concerns as well as housekeeping concerns. The complainant indicated that when they visited resident #004 12 days earlier, they found mouse feces in the resident's clothing drawers. The complainant indicated that they had reported this issue to staff, and that the area was cleaned by housekeeping on one occasion but continued to be an issue at the time of inspection.

Observations by the inspector on an identified date, showed in resident #004's shared room, two dressers were located on resident's side of the room. When the inspector moved garments aside in one of the drawers, mouse feces was identified. The drawer was observed by ESM #123 who confirmed that the drawer had mouse feces inside. Further observation was conducted in the shared resident room which showed a closet located in the shared resident room. The inspector observed mouse feces on the floor near the track of the closet's sliding door. Upon opening the closet sliding door, the inspector and ESM #123 observed mouse feces on the floor of the closet among resident's belongings.

Review of service records from the home's licensed pest control contractor showed that on an identified date, resident #004's shared room had been serviced related to house mice activity. The service record indicated that snap and glue traps were placed in the room and a small hole was found under the baseboard heater which required repair.

In interviews, HA #126 and PSW #127 indicated that they had not observed mouse droppings in resident #004's drawers, nor did they receive any reports or complaints from the family member of resident #004. Both staff members indicated that they would have reported any such issues to the ESM for follow-up.

In an interview, ESM #123 indicated that the job duties of the housekeeping staff did not include any routine cleaning of the drawers in resident rooms, nor the floors in the closets, though if sanitation concerns were identified they could clean the areas. The ESM indicated that the room had been noted to have mouse activity earlier in the year, which had been serviced by the pest control contractor. The ESM indicated that the area under the baseboard heater had been patched to prevent mice from using the hole as a route of access. The ESM acknowledged

that resident #004's drawer as well as the closet in the shared resident room had mouse feces present, and were not kept clean and sanitary. [s. 15. (2) (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 the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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 has failed to ensure that actions taken with respect to resident #004 under the home's skin and wound program, specifically weekly reassessments of identified areas of altered skin integrity, were documented.

According to O. Reg. 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that, (a) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Review of the progress notes and eTAR indicated that in an identified month, resident #004 had 12 identified alterations in their skin integrity, including seven

identified areas of altered skin integrity of a specified type.

Review of the progress notes indicated that for the seven identified areas of altered skin integrity, there was no wound assessment information documented weekly during the above identified month, according to the home's wound assessment policy. In many instances, it was documented that the resident was receiving skin and wound care while they were out of the facility for medical treatments, the resident refused care, or staff indicated that they carried out treatments for the areas of altered skin integrity, but did not document any assessment findings as per the home's wound assessment policy.

Review of the assessments in the electronic health record indicated that the Skin & Wound Evaluation V6.0 was completed for one identified area of altered skin integrity on an identified date, and a progress note was entered on an identified date one week earlier for a second area of altered skin integrity. Both entries included required documentation for wound assessments. There were no other wound assessments identified in the health record for the seven identified areas of altered skin integrity for resident #004.

RPN #133 was interviewed and indicated that they had frequently provided care to resident #004 during the above identified month. The RPN indicated that they would typically assess the resident whenever they had scheduled treatments and dressing changes for their areas of altered skin integrity. The RPN indicated that they documented their findings for resident #004's areas of altered skin integrity in the progress notes and confirmed entering notes such as "dressing changed", "dressing intact", "refused wound care", or "wound dry". They acknowledged that their progress notes did not include detailed assessment findings for the resident's areas of altered skin integrity. The RPN was also unable to identify any other progress notes or assessments, other than those identified above, that included wound assessment information as per the home's wound assessment policy for resident #004's identified areas of altered skin integrity. The RPN indicated that the home's wound care nurse typically completed the weekly wound assessments using a smartphone application.

RPN #109, the home's wound care nurse, indicated that they were responsible for the weekly skin and wound assessments for all residents in the home, and that they would typically assess resident #004's areas of altered skin integrity on a specified day each week. They said that they used a wound assessment application on a smart phone that included a photograph of the wound and

assessment details as per the home's wound assessment policy (e.g., location, type, dressing status, drainage, signs of infection, etc.). RPN #109 also indicated that registered staff on the floor were expected to complete weekly assessments if the wound care nurse was unavailable and document their findings in in the progress notes, including wound assessment items as specified in the home's wound assessment policy. RPN #109 confirmed that weekly assessments were clinically indicated for resident #004's identified areas of altered skin integrity due to identified indicators. They acknowledged that they did not complete the weekly assessments using the specified tool for resident #004's seven identified areas of altered skin integrity of a specified type, and stated that the resident often refused skin care and assessments. The RPN was asked if they returned the next day to attempt to do the weekly assessment when the resident refused, and they indicated that they normally did not return.

The DOC acknowledged that resident #004's weekly skin assessments should have been documented, either in the progress notes by registered staff on the floor during dressing changes, or by the wound care nurse using the wound assessment application on the smartphone. In either case, the DOC indicated that the wound assessment findings should have been documented as per the home's policy. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under this Act.

a. On May 31, 2019, the following compliance order (CO #001) from inspection #2019_746692_0013 under LTCHA, 2007, c. 8, s. 6. (7) was issued:

The licensee must be in compliance with s. 6. (7) of the LTCHA.
Specifically the licensee must:
a) Ensure all residents' Advance Directives are followed as per the residents wishes.
b) Educate/re-educate all relevant staff on the process related to various Advance Directives.
c) Maintain records, including the attendees, date(s), and material reviewed.

The compliance due date (CDD) was August 6, 2019.

The licensee completed steps (a) and (c) in CO #001.

The licensee failed to complete step (b) in CO #001.

In an interview, ED #100 indicated that all registered staff were considered relevant staff. The ED stated that the registered staff were provided education on the process related to various Advance Directives in the home.

A record review of the home's training records titled Ministry of Health Findings, indicated that 14 per-cent of the registered staff did not receive education on the process related to various Advance Directives in the home, which included the home's policies on code blue and prevention of error-based transfers (PoET).

In an interview, the above finding was reviewed with ED #100. Based on the information, the home did not ensure that all registered staff were educated on the process related to various Advance Directives in the home. The home did not complete step (b) of CO #001.

b. On May 31, 2019, the following compliance order (CO #002) from inspection # 2019_746692_0013 under LTCHA, 2007, c. 8, s.19. (1) was issued:

The licensee must be in compliance with s. 19. (1) of the LTCHA.

Specifically the licensee must:
a) Protect all residents from abuse from anyone.
b) Ensure all relevant staff are educated/re-educated on the purpose, process and expectations required when completing the one-to-one resident monitoring shift.
c) Maintain records, including attendees, date(s) and the material reviewed.

The CDD was August 6, 2019.

The licensee completed step (a) in CO #002.

The licensee failed to complete steps (b) and (c) in CO #002.

In interviews, Nurse Clinician (NC) #112 and ED #100 indicated that all registered staff, staffing clerks and PSWs assigned to do one-to-one resident monitoring were considered to be relevant staff by the home. They stated that PSW staff had received education on the process and expectations of one-to-one monitoring from the staffing clerks, when a PSW was scheduled for one-to-one resident monitoring.

A review of the home's training records titled Ministry of Health Findings, indicated that 14 per cent of the registered staff did not receive education on the purpose, process and expectations required for one-to-one resident monitoring.

A further review of the documentation indicated that the home did not maintain records of the PSW staff who received one-to-one resident monitoring education from the staffing clerks and the dates when the education was conducted.

In an interview, Staffing Clerk #110 confirmed that education records were not

maintained for the PSW staff who received one-to-one resident monitoring education.

In an interview, the above finding was reviewed with ED #100. Based on the information, the home did not ensure that all registered staff were educated on the purpose, process and expectations required when one-to-one monitoring was completed, and did not maintain the required records of the PSW staff who received the one-to-one resident monitoring education.

The home did not complete steps (b) and (c) of CO #002. [s. 101. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee complies with every order made under this Act; specifically:
- to ensure that all registered staff in the home who were not provided education related to advance directives as ordered by CO#001 (Inspection #2019_746692_0013) receive education on the process related to various Advance Directives in the home which included the home's policies on code blue and prevention of error-based transfers; and
- to ensure all direct care staff who did not receive training as ordered by CO #002 (inspection #2019_746692_0013), are educated/re-educated on the purpose, process and expectations required when completing one-to-one resident monitoring, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a medication incident involving resident #005 was documented.

During a review of resident #005's physician orders, a telephone order from an identified date, indicated to change the administration time of an identified medication to a specified scheduled administration time to be started two weeks after the transcription of the telephone order, and to discontinue the previous order for the identified medication. A review of the resident's eMAR for the month of the transcription of the telephone order indicated that the administration of the identified medication had been scheduled for a specified administration time and was discontinued on the date the telephone order was transcribed. Four days later, an entry for the identified medication was found which indicated the administration was scheduled for one specified time and to be changed to another specified time 2000 hrs starting two weeks following the transcription of the telephone order. The eMAR showed that the identified medication had not been administered as prescribed for three consecutive identified days.

In an interview, RPN #114 indicated that they transcribed the telephone order on the above identified date for the identified medication order for resident #005. The RPN stated that they reviewed the order three days later, and realized they transcribed the order incorrectly which resulted in the resident missing three doses of the identified medication on the three consecutive dates following the transcription of the telephone order. During the interview, the RPN indicated they considered the incident to be a medication error. The RPN stated that when a medication incident occurred, registered staff were expected to complete a medication incident form, and confirmed that they did not complete the form.

In an interview, DOC #101 indicated that registered staff were expected to complete a medication incident report when a medication incident occurred, and the staff should notify the ADOC of the incident. The DOC acknowledged that the medication incident for resident #005 was not documented by RPN #114, until it was brought to the home's attention by the inspector. [s. 135. (1)]

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*

Issued on this 8 th day of November, 2019 (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 ADAM DICKEY (643) - (A1)
Inspection No. / No de l'inspection :	2019_767643_0027 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	008748-18, 009053-18, 009456-19, 011032-19, 011033-19, 011034-19, 014079-19, 017624-19 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 08, 2019(A1)
Licensee / Titulaire de permis :	Rykka Care Centres LP 3760 14th Avenue, Suite 402, MARKHAM, ON, L3R-3T7
LTC Home / Foyer de SLD :	Hawthorne Place Care Centre 2045 Finch Avenue West, NORTH YORK, ON, M3N-1M9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Charlotte Altenburg

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 Rykka Care Centres LP, you are hereby required to comply with the following order (s) by the date(s) set out below:

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_746692_0013, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 6. (7) of the LTCHA.

Specifically the licensee must:
1) Ensure that resident #002, and all other residents who require assistance with feeding, are provided with the appropriate level of assistance at meals and snacks as per their plan of care;
2) Ensure that resident #002, and all other residents, are provided with labeled individualized snacks as per their plan of care to meet their nutrition and hydration needs;
3) Ensure that resident #004, and all other residents, are provided with falls prevention and management interventions including hip protectors as per their plan of care;
4) Develop and implement an auditing system to ensure staff are providing care to residents as set out in the plan of care related to the provision of labeled snacks and fall prevention and management interventions; and
5) Maintain a written record of audits conducted in the home. The written record must include the date of the audit, the resident's name, staff member (s) audited, the name of the person completing the audit and the outcome of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #002 and #004 as specified in the plan.

On May 31, 2019, the following Compliance Order (CO #001) from inspection report 2019_746692_0013; amended on June 3, 2019, inspection report #2019_746692_0013 (A1) made under LTCHA 2007, c. 8, s. 6. (7) was issued:

The licensee must be in compliance with s. 6. (7) of the LTCHA.
Specifically the licensee must:
a) Ensure all residents' Advance Directives are followed as per the residents wishes.
b) Educate/re-educate all relevant staff on the process related to various Advance Directives.
c) Maintain records, including the attendees, date(s), and material reviewed.

a. Review of resident #002's current written care plan showed the resident required assistance with feeding. The care plan further showed resident #002 was to be provided with two specified snacks and a specified beverage at an identified snack pass.

Observations by Inspector #643 on an identified date, showed resident #002 seated at a dining table with one of the above specified snacks and the above specified beverage on the table. No staff were present to assist with feeding resident #002 their snack. Further observation the following day showed resident #002 seated at the dining table with one of the above specified snacks and the above specified beverage on the table. A spoon was in resident #002's hand; however, no staff were present assisting the resident to consume their snack.

In an interview, PSW #104 indicated that they had provided residents on the unit with the above identified snack pass on the first above identified date. PSW #104 indicated that residents who required assistance with eating would be served snack by the PSW completing snack pass, who would also stay with the residents and assist them with feeding. PSW #104 further indicated that resident #002 received the above specified snacks and beverage. They would show the resident the items and resident #002 did not always choose to have one of the specified snacks. PSW #104 indicated that they would open the snack container for resident #002 and put the spoon inside and let resident #002 know that it was time for the snack. PSW #104 further indicated that resident #002 did not prefer assistance with feeding and would leave the snacks with the resident to consume themselves.

Observations by Inspector #643 on a third identified date showed resident #002 could not be located on the unit while staff provided the above identified snack pass. PSW #102 indicated that the resident might be off the unit with family, or in an off unit activity. The inspector observed resident #002's above specified snacks and beverage in an ice bath on the snack cart. The inspector located resident #002 in another resident area of the home. The resident was observed to have returned to the unit approximately 25 minutes later, and was seated at their table in the dining room with no snack provided.

In an interview, DA #128 indicated that the snack cart was returned to the servery on the unit and their co-worker had returned it to the main kitchen. Inspector #643 interviewed DA #121 who indicated that when a resident does not take a labeled snack, it is returned to the main kitchen from the unit servery. DA #121 further indicated that resident #002's labeled snacks were returned to the main kitchen on the third identified date.

In an interview, PSW #140 indicated that they had provided the identified snack pass to residents on the unit on the third identified date. PSW #140 indicated that when they provided snacks, resident #002 was not present on the unit to receive their snack, and did not provide it. PSW #140 indicated that there was no process in place to reserve a labeled snack for a resident who was not on the unit when snack pass occurred, and they would document in point-of-care (POC) indicating resident not available.

In an interview, ADOC #115 indicated that when a resident was to receive a labeled snack, according to their plan of care, staff were expected to provide the snack to the resident. The ADOC indicated that when a resident was going to an off unit activity, the staff would still be expected to provide the snack as per the resident's plan of care. The ADOC indicated that if a resident had an activity scheduled at the same time as snack pass, arrangements should be made to ensure that the resident receives their labeled snack as ordered by the RD.

In an interview, RD #106 indicated that resident #002 was to receive both specified snacks at the identified snack pass, with the specified beverage as indicated in the written care plan. RD #106 further indicated that resident #002 was to be provided assistance with feeding, though the resident did not prefer to be assisted and would feed themselves at times with supervision from staff. RD #106 indicated that as

resident #002's care plan instructed staff to provide assistance with feeding, a staff member should be with resident #002 during snack pass to supervise and provide the assistance required when needed.

b. A complaint was submitted to the MLTC by resident #004's family member with concerns about multiple care areas including falls sustained by the resident. The complainant indicated that the home reported to them on several occasions that resident #004 had been found on the floor.

Review of resident #004's current written care plan showed they were at risk for falls and had falls prevention interventions in their care plan, including to ensure specified equipment was in place at all times. The care plan showed resident #004 had been noted by staff to remove the above specified equipment at times.

Observations conducted by the inspector on an identified date, showed resident #004 in bed; the resident did not appear to have the above specified equipment in place. Approximately 40 minutes later, the inspector observed resident #004 with RPN #105, who checked the resident for the above specified equipment and indicated they were not in place. RPN #105 looked for the equipment in resident #004's room and found a portion of the equipment which was not complete.

In an interview, PSW #127 indicated that they had been providing care to resident #004 for the last 10 months, and had not been aware that the use of the above specified equipment was included in their written care plan or kardex. PSW #127 indicated that they did not ensure that the specified equipment was in place for resident #004, and the resident had not been using it during their shift.

In an interview, RPN #105 indicated that they were aware of resident #004's fall risk and history of falls. RPN #105 indicated that resident #004 had interventions in place including the above specified equipment. They indicated that resident #004 should be using the specified equipment at all times, and acknowledged that the resident was not using it that day. RPN #105 indicated that the equipment should be kept in the resident's room, and had located a portion of the equipment but it was not complete.

In an interview, interim ADOC #111 indicated that the specified equipment would be provided by the nursing staff for residents who were assessed to need it to prevent

injury from falls. ADOC #111 indicated that when a resident received the specified equipment, they were provided with two sets, in case one was in the laundry or dirty. ADOC #111 indicated they were not aware that resident #004 did not have the specified equipment available, and that management could provide another set if lost. They indicated that as resident #004 did not have the equipment in place, and did not have the equipment available, the care was not provided as specified in resident #004's plan of care.

The severity of this issue was determined to be a level 2 as there was minimal harm/ minimal risk to the residents. The scope of the issue was determined to be a level one as each finding affected one of three residents reviewed. The home had a level 5 compliance history as the order is being re-issued to the same subsection and the home has had four or more compliance orders (CO) in the last 36 months. The home's compliance history included the following non-compliance with the same subsection that included:
- written notification (WN) issued September 11, 2017 (2017_527665_0004);
- WN and voluntary plan of correction (VPC) issued August 4, 2017 (2017_595604_0011);
- WN and CO issued November 29, 2017 (2017_644507_0016), with a compliance order due date (CDD) of January 12, 2018; and
- WN and CO issued May 31, 2019 (2019_746692_0013), with a CDD of August 6, 2019.

(643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 06, 2019

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with s. 50. (2) of the Regulation (O. Reg. 79/10).

Specifically, the licensee must:
1) Develop and implement a system to ensure that registered staff complete a preliminary assessment using a clinically appropriate assessment tool, for residents with new areas of altered skin integrity;
2) Ensure that residents #002 and #004, and any other resident with altered skin integrity, are assessed weekly by registered staff;
3) Ensure that when resident #002 and #004, and any other resident with altered skin integrity, refuses a skin and wound assessment either weekly or as otherwise ordered, the refusal is communicated to oncoming registered staff to ensure that the resident is re-approached to complete the assessment as required;
4) Develop an on-going auditing process to ensure that residents exhibiting altered skin integrity receive a skin assessment by a member of the registered staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment; and
5) Maintain a written record of audits conducted in the home. The written record must include the date of the audit, the resident's name, the name of the person completing the audit and the outcome of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #002 and #004 who were exhibiting altered skin integrity 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. A complaint was submitted to the MLTC from resident #002's family member related to care concerns, including skin and wound care related to specified areas of altered skin integrity which were reported to them. The complainant stated that the areas of altered skin integrity were not healing.

Review of resident #002's progress notes showed that on an identified date, RPN #122 noted two specified areas of altered skin integrity. According to the progress note, RPN #122 attempted to clean the site with an identified antimicrobial agent and assess further; however, the resident did not allow for the assessment to be

completed. The progress notes showed that a skin and wound referral was initiated the same day, for the new areas of altered skin integrity. Progress notes further showed that RPN #107 attempted to assess the areas on the following day, though resident #002 refused to allow the RPN to touch the general area around the altered skin integrity. A progress note four days following the discovery of the specified areas of altered skin integrity, showed RPN #109, who was the skin and wound care lead in the home, saw resident #002, and unsuccessfully attempted to assess the resident and would follow-up.

Review of the assessments in the electronic health record did not show an assessment for the above mentioned areas of altered skin integrity. Review of resident #002's electronic treatment administration record (eTAR) showed a specified treatment order was initiated 12 days following the discovery of the areas of altered skin integrity to be carried out twice daily. No previous treatment order was found related to resident #002's areas of altered skin integrity.

In an interview, RPN #122 indicated that the process in the home was when a new area of altered skin integrity was discovered a referral should be sent to the skin and wound care lead to do an initial assessment of the area and treat according to the home's wound care algorithm. The RPN indicated that they had received a report from a PSW staff about the altered skin integrity for resident #002 on the above identified date. RPN #122 indicated that they had noted the above areas of altered skin integrity, though the resident was not allowing the RPN to assess the areas. RPN #122 indicated that they completed a referral to the skin and wound lead to assess the area and communicated to the oncoming shift to follow up.

In an interview, RPN #109 indicated that the process in the home when a new area of impaired skin integrity was discovered was for registered staff to do an initial assessment of the area and provide treatment according to the home's skin and wound care algorithm. RPN #109 further indicated that the home was utilizing a smartphone application to generate a complete skin and wound assessment using pictures to document progression of an area of altered skin integrity and effectiveness of treatment. They indicated that they had received a referral for resident #002's above specified areas of altered skin integrity and attempted to assess four days following the discovery of the areas, though the resident refused three times. RPN #109 indicated that there had been no further attempts made to complete an assessment, and that the area was not assessed using the clinically

appropriate assessment tool specifically designed for skin and wound assessment.

b. A complaint was received by the MLTC related to concerns about resident #004's skin integrity.

Review of the progress notes and eTAR indicated that in an identified month, the resident had 12 specified alterations in their skin integrity, including three identified areas of altered skin integrity of a specified type.

The skin and wound assessments for resident #004 were reviewed by Inspector #722 in the progress notes and assessment tab in the electronic health record. No skin and wound assessments were identified using an assessment tool that included basic wound assessment details (i.e., location, size, drainage, signs of infection, and treatment) for the three above identified areas of altered skin integrity.

The home's Wound Assessment Documentation policy, last revised April 2010, indicated that registered staff were required to include the following in their wound assessment documentation: status, location, size, drainage, odour, necrotic tissue, signs of infection, and treatment. There were no progress notes or assessments for the three identified areas of altered skin integrity that documented this information.

RPN #133 indicated during an interview that for any new alteration in skin integrity, the registered staff were expected to complete an initial assessment of the wound and enter their findings in the electronic record, using one of two specified skin alteration documentation tools. They acknowledged that neither of these tools were used for the three above identified areas of altered skin integrity for resident #004. The RPN indicated that they were also expected to send a referral to the home's wound care nurse, who completed wound assessments for all residents each week using a smartphone application.

RPN #109, the home's wound care nurse, indicated that when they received a referral, they would assess residents' areas of altered skin integrity using an assessment application on a smartphone, which included a photograph of the area, and all the assessment details required according to the home's assessment policy. The RPN stated that the wound assessment information from the smartphone application populated the Skin & Wound Evaluation V6.0 form in the electronic health record. RPN #109 confirmed that the Skin & Wound Evaluation V6.0 was not

completed for resident #004's three identified areas of altered skin integrity.

The DOC confirmed that resident #009's three identified areas of altered skin integrity should have been assessed using the smartphone application that populated the Skin & Wound Evaluation V6.0 form in PCC. They acknowledged that there was no assessment completed using a clinically appropriate tool for resident #004's three identified areas of altered skin integrity.

The severity of this issue was a level 2 as there was minimal harm/ minimal risk to the residents. The scope was level 2 as the non-compliance affected two of three residents reviewed. Compliance history was a level 3 as there was previous non-compliance with the same subsection that included:
- written notification (WN) and compliance order (CO) issued September 11, 2017 (2017_527665_0004), with a compliance due date (CDD) of January 12, 2018.
(722)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 18, 2020

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

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2019_746692_0012, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with s. 131. (2) of the Regulation (O. Reg. 79/10).

Specifically the licensee must:
a) Ensure that for residents #001, #005 and all other residents, that medications with scheduled administration times are administered at their prescribed time;
b) Ensure that resident #005 and all other residents receive all medications prescribed to them in accordance with the directions for use specified by the prescriber; and
c) Ensure that for resident #005 and all other residents that when a medication administration is refused, registered staff make additional attempts to administer the medication and if unsuccessful document in the electronic record the attempts to administer and the resident's refusal.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that drugs were administered to residents #005 and #001 in accordance with the directions for use specified by the prescriber.

Compliance Order #001 was served on May 31, 2019, under inspection report #2019_746692_0012 with a compliance due date of July 16, 2019. The licensee was ordered to be compliant with r. 131. (2) of the Ontario Regulation 79/10.

Specifically the licensee was ordered to:
a) Ensure that medications are administered to residents #001, #005, #019, and any other resident, at their prescribed time;
b) Conduct and document scheduled audits of resident's electronic Medication Administration Record (eMAR); and
c) Maintain a record of the results of the audit and the actions taken to address the concerns.

a) During a review of resident #005's physician orders, a telephone order from an identified date, indicated to change the administration time of an identified medication to a specified scheduled administration time to be started two weeks after the transcription of the telephone order, and to discontinue the previous order for the identified medication. A review of the resident's eMAR for the month of the transcription of the telephone order indicated that the administration of the identified medication had been scheduled for a specified administration time and was discontinued on the date the telephone order was transcribed. Four days later, an entry for the identified medication was found which indicated the administration was scheduled for one specified time and to be changed to another specified time starting two weeks following the transcription of the telephone order.

In an interview, RPN #114 indicated that they transcribed the telephone order on the above identified date for the identified medication order for resident #005. The RPN stated that they reviewed the order three days later, and realized they transcribed the order incorrectly and was not clear, resulting in the medication being discontinued. The RPN indicated that the intended direction of the order was only to change the time of administration starting two weeks later. The incorrect transcription of the order resulted in the resident missing three doses of the identified medication on the three consecutive dates following the transcription of the telephone order. RPN #114 acknowledged that resident #005 did not receive the identified medication as prescribed.

b) A review of resident #001's quarterly medication review for an identified three month period, showed the resident was prescribed an identified medication at three specified scheduled times daily. Review of the resident's medication administration audit report for the final two week period during the identified three month period, showed that two of the resident's specified scheduled doses of the identified

medication were administered together by RPN #141 on two consecutive identified dates.

In an interview, RPN #141 confirmed they had administered the two scheduled doses of resident #001's identified medication at the same time on each of the above dates. The RPN indicated the resident exhibited responsive behaviours and would at times refuse the first scheduled dose of the identified medication. They indicated that when that occurred they would save the first scheduled dose and administer it together with the second scheduled dose. The RPN indicated they should have communicated this to the physician and documented the resident's preference in a progress note. RPN #141 confirmed they did not administer resident #001's identified medication as prescribed.

In an interview, DOC #101 indicated it was the home's expectation for medications to be administered as prescribed and at their prescribed time. The DOC confirmed that they were made aware by ADOC #113, that resident #005 missed three doses of their above identified medication. During the interview, the DOC further stated when a resident refused their medication(s), the expectation was for the registered staff to attempt to administer again after a few minutes and document in the eMAR as refused. The DOC indicated that RPN #141 should have communicated resident #001's preference for their medication administration in a progress note, and in the physician communication book. As a result of this information, the DOC acknowledged residents #005 and #001 did not receive their medications as prescribed and at the prescribed time.

The severity of this issue was a level 2 as there was minimal risk to the residents. The scope was level 2 as the non-compliance affected two of four residents reviewed. Compliance history was a level 5 as the compliance order (CO) is being issued to the same subsection and the home had four or more COs issued in the last 36 months. The home's compliance history included the following non-compliance with the same subsection that included:
- written notification (WN) and CO issued August 4, 2017 (2019_595694_0011), with a compliance due date (CDD) of November 1, 2017;
- WN and voluntary plan of correction (VPC) issued December 13, 2018 (2018_642698_0006); and
- WN and CO issued May 31, 2019 (2019_746692_0012), with a CDD of July 16, 2019. (665)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Nov 15, 2019

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

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:

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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

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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 8 th day of November, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by ADAM DICKEY (643) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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